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ABSTRACT

This compilation of short reports distributed to preschool teachers in the Pittsburgh area covers four main topics: (1) Adoption (2) Expressive Art Therapy, (3) The Infant, and (4) Learning Disorders in Young Children. The adoption section includes reports pertaining to the adoption process in Pennsylvania, adoptive parents' legal rights, medical and psychological issues in adoption, and the importance of parent/child interaction in cognitive development. The expressive art therapy section includes suggestions for some specific therapeutic uses of drama, art, music and dance activities with normal, disturbed, and handicapped children. The infant section contains discussions of topics dealing with early language acquisition, a psychoanalytical approach to infancy, sensorimotor development, high-risk infant survivals, and developing stimulating home environments for infants. The last section, which pertains to learning disorders in young children, includes information on minimal brain dysfunction, sensorimotor disabilities in preschool children and infants (including remediation activities), speech and language disability identification, hyperactive children and stimulant drugs, the value of play as treatment, and dealing with learning disorders in the classroom. (ED)

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Volume 8, No. 1-4

Mary Frank, Editor

Themes: Adoption

Expressive Art Therapy

The Infant

Learning Disorders and Young Children

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ADOPTION

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ADOPTION

The comfortable life has an uncomplicated flow. The cycle of human development brings a time of unfolding needs to be experienced and fulfilled. With fulfillment there is satisfaction and growth. When these needs are thwarted, there is frustration and interference with emotional progress. Adoption is a resolution for these unmet needs.

There is a warm beauty to life when all adults, who are ready for parenting, experience the miracle of birth; when every woman, who is pregnant, is ready to be a mother; and every baby is born to parents who are emotionally prepared to care. In this real world, adjustment is required to help the infant, the pregnant woman, and the waiting couple. Adoption is not automatically a simple solution. There is a great variety of human emotions, which require awareness, working through, and an eternal acceptance of reality.

The pregnant girl or woman, married or unmarried, who is not ready or able to parent her expected child needs an option. In this day of almost universally available abortion, this is an alternative. It is not a solution for everyone. The creation of life for some people has a moral responsibility which requires the presentation of a baby to birth. The surrender of a child to an agency or to someone else to nurture and rear is an emotionally demanding act. In fairness to herself and the baby, reality requires a reasonable and logical decision. Of course, the memory lingers. If the woman utilizes this experience to grow and to develop a timetable in harmony with herself, eventually the impact fades from vivid color to pastel.

Parenting has many components to it. First of all, it is the fulfillment of life, the normal human stage to nurture and care for children. Beyond that, it may arouse areas of sensitivity about one's sexuality or one's adequacy as an individual. It is the honor which admits one to the inner circle of belonging to the great league of parents. There is a tremendous frustration in wanting a pregnancy and not being able to will it or to accomplish it. While conception can be prevented, it is impossible to order it on demand. Usually a couple arrives at the decision of adoption after some seasons of heartache and disappointment. Hopefully, a baby will fulfill them. They, too, have emotional homework. Loving children for themselves requires a great maturity, a greater peace with oneself, than loving the extension of one's own ego. The conflict of reality and fantasy is there to handle.

In this sequence of events the infant is powerless. His whole life and being will be dependent upon the wisdom and compassion of the people who give him life and the parents who rear him. The child and the adolescent he becomes will inevitably encounter the fantasy of wishing he had been born to people who were ready and able to rear him. In his primary evaluation of life, he will wonder how responsbile he was for losing one set of parents and if he will surely jeopardize the adoptive relationship as well. He will visit the make-believe land of considering the kind

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of human beings the original people were. His new parents, without being overly threatened, need to understand the search for himself. He cannot be given direct identification because a surrender is forever. However, he will hopefully be given facts which help him understand and make peace with himself. He needs to be loved for himself and given support in questing for his own reality.

Society has developed laws to provide a legal framework of protection for the three parties involved in adoption. Each state has its own code. Ideally, there should be a national standard and a consistent legal base in all of the fifty states. Social agencies, public and private, are the enablers to provide practical and emotional services. Currently, there are many more potential parents than available children in the most requested categories. However, these are creative and exciting times for the agencies and parents who can expand their dreams. The era of the "adoption only" of the gold[illegible]red child has passed. Adoption must be a right of any child, who requires it re[illegible]rdless of sex, age, race, physical or emotional problems. Any child, who can respond to family life and grow to become a functioning adult, needs parents. Agencies need the commitment to provide parents, rather than simply providing babies for parents. The child's timetable cannot wait. His development is fragile.

The character of being human is to dream. Everyone has fantasies of self, love and destinies. It is important to recognize the disappointment and emotional journey of each of the three parties involved in adoption. The use of denial of feelings confuses the final relief and acceptance of life. The woman needs to be free to find herself. The child's time is now. He immediately requires parents who are ready and able to tend to him. A couple needs a child to fulfill their parental aspirations. Adoption is the recognition of a variety of needs and putting them in a position of hopeful satisfaction. Adoption is not the same as giving birth to children and living happily ever after. In any course of parenting, there is not a simple promise of living happily ever after. From the beginning, adoption requires the courage to climb the emotional mountains. This can be a healthy head start of accepting reality and acknowledging the humanness of fantasies. Adoption is a great adventure.

John R. Anderson

THE ADOPTION PROCESS IN PENNSYLVANIA

I. The Adoptive Relation

An adoption decree creates the legal status of child and parent between adoptee and adopter. The Pennsylvania Adoption Act of 1971 declares that the adoptee ". . . shall have all the rights of a child and heir of the adopting parent or parents, and shall be subject to the duties of a child to him or them. . . ."

II. The Adoption Process

The adoption process is relatively uncomplicated. Within thirty days after acquiring custody from an agency or parent, the prospective adopting parents must file with the court a statement of intention to adopt. Private placements are investigated by the court at this time, although agency placements, already having been investigated by the agency, are not. After six months, the prospective adopting parents may file a petition for adoption. The court sets a hearing date and refers the petition to court investigators. Both private and agency placements are then investigated a second time. At the hearing, the adopting parents must appear in court with the child for a brief, formal proceeding after which the court decress the adoption.

III. Termination of Parental Rights

Creation of the adoptive relation necessarily entails termination of the original parent-child relationship by parental consent or voluntary relinquishment or involuntary termination of parental rights followed by entry of the adoption decree. Where both parents of the adoptee are deceased or both consent to the proposed adoption, there is no problem in completing the procedure. Where, however, one parent is unavailable or unwilling to consent, additional action is required.

A. Voluntary Relinquishment

The parent of a child (in virtually all cases of illegitimacy, for example, the mother), after surrendering custody of the child to an adoption agency or to prospective adopting parents, may file with the court a petition to voluntarily relinquish all parental rights vis-a-vis the child. A hearing date is set and the parent then appears before the court in chambers. After ascertaining that the act of the parent is voluntary and intelligent, the court enters a decree terminating parental rights. The parent then drops out of the adoption process.

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B. Involuntary Termination

If a parent has neither consented to the adoption nor voluntarily relinquished parental rights, completion of the adoption process requires that those rights be involuntarily terminated. The proceeding may be initiated by one parent against the other, by an agency, or by prospective adopting parents having custody of the child. The Adoption Act of 1971 specifies the grounds for termination: ". . . (1) the parent by conduct continuing for a period of six months has evidenced a settled purpose of relinquishing parental claims to a child, or has refused or failed to perform parental duties; (2) the repeated and continued incapacity, abuse, neglect, or refusal of the parent has caused the child to be without essential parental care, control or subsistency necessary for his physical or mental well-being and the conditions and causes of the incapacity, abuse, neglect or refusal cannot or will not be remedied by the parent; or (3) the parent is the presumptive but not the natural father of the child."

IV. The Principle Problem

The inability to dispose of parental rights accounts for virtually all frustrated adoptions. Perhaps the most troublesome problem in this area concerns disposition of the rights of the father of an illegitimate child. In the past, the natural father of an illegitimate child was considered to have no rights cognizable in an adoption proceeding. The language of the Adoption Act of 1971 specifies that an adoption decree may be entered without such father's consent. The 1972 United States Supreme Court decision of Stanley v. Illinois, however, held that the natural father of illegitimate children could not be deprived of their custody by the state without notice and a hearing solely upon the basis of a presumption arising out of the fact of illegitimacy that he was an unfit parent. In so holding, the court recognized that the natural father of an illegitimate has a legally protected interest in the parent-child relationship. Disposition of subsequent cases indicated that the Stanley requirements of notice and opportunity for hearing apply in adoption proceedings. The exact meaning of Stanley, however, remains uncertain. Nevertheless, broadly stated, the decision requires that the natural father of an illegitimate child be accounted for in some fashion before the adoption process can be validly completed.

In practice, where it appears that the identity or whereabouts of the father are unknown and that he has taken no interest in the child, the court may often dispense with consideration of his rights and enter an adoption decree without notice to him, his consent, or termination of his parental rights. Adopting parents should be advised that this entails the possibility of future court action in the event that the father reappears and asserts his rights in a habeas corpus proceeding. In the unlikely event that the father in such case does appear, his prospects for avoiding the adoption and acquiring custody are dim.

Claudia Titelman

THE LEGAL RIGHTS OF ADOPTIVE PARENTS

With the recent advances in child development theory and the expanding concern with equality for all under the law, the legal rights of adoptive parents have become a focus for discussion. The articles reviewed here reflect the growing social concern with the parenting process and adjustments the culture must make to enhance this process. They also indicate that much work is left to be done in behalf of the adoptive child and his parents.

Cominos (1971) discusses the right of adoptive parents to pursue and receive information on the adopted child's background including medical, cultural and ethnic data. The author sees the necessity of increasing adoptive parents' awareness of their prerogative in this area because of its frequent neglect by the placing agencies.

The author's emphasis is on the importance of the child's hereditary medical background. Specifically mentioned are genetically transmitted conditions that, while rare, are very serious. Early diagnosis of the condition is undermined if the adoptive parents are not aware of the existence of such conditions in the child's natural family, especially the natural parents. The list of clearly inherited disorders includes Huntington's Chorea, muscular dystrophy, diabetes, phenylketonuria (PKU), Tay-Sachs disease, cystic fibrosis, hemophilia and sickle-cell anemia. Other conditions, such as cancer, coronary artery disease, rheumatoid arthritis and allergies, have been shown to run in families, although the genetic mode of transmission is not as clear, and may be described as a constitutional vulnerability. The author points out that 6 percent of all newborns will have a defect or an illness that has been transmitted genetically.

Cominos would also advocate sharing information on major emotional disorders, i.e., schizophrenia and manic depressive psychosis, which she contends are influenced by genetic factors. Placing agencies have traditionally avoided the sharing of such information with adoptive parents, since they did not want the child to be viewed with suspicion. Cominos, however, emphasizes the right of adoptive parents to know what risks they are taking when they adopt a child.

Mech also identified the unavailability of background information on the child as an important issue. However, this author's stated support is for the development of the child's identity, not the rights of the adoptive parents, per se.

Another issue of concern to Mech is that of the eligibility requirements adoptive parents must meet. A traditional policy has been to place a child with adoptive

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parents who have membership in the organized religion designated by the natural parents. This, in effect, restricts the possibility of adoption to certain couples and eliminates the possibility for others. Mech would recommend a policy change with regard to this issue.

Also cited and encouraged is the current tendency to de-emphasize infertility as an eligibility requirement. Here, the author's concern is with the adoptive parents and the debilitating effect this requirement has had on the self-esteem of each partner and on the relationship.

Samuels (1973) presents recommendations for legal reform of certain adoption procedures, based on the study of legal decisions in adoption cases. The recommendations are an attempt to better safeguard the rights of all parties involved in the adoption.

Strongly recommended is a more reliable procedure for relinquishment of parental rights so that this cannot later be withdrawn by the natural parents. Such a reform would help to prevent court disputes which can occur after the child has been placed with adoptive parents.

Also suggested here are changes in the eligibility requirements for adoptive parents, specifically, that the minimum age be dispensed with and that the religious requirement not be imposed. Access to knowledge of natural parentage is also supported. An additional suggestion is financial assistance, especially for persons adopting children with unusual medical or other expenses. This aid is not legally available to adopting parents at the present time.

Ridlon (1971) discusses the Pennsylvania Adoption Act of 1970, effective January 1, 1971, and illuminates some of the areas of improvement and potential difficulty in inplementing the act. It is an excellent description of the adoption process from the legal perspective.

With regard to adoptive parents' rights, the issue of background information was given thorough attention by this author. The intermediary agency is required to furnish the court with the results of the background investigation on the child, but it is not made available to the adoptive parents. Ridlon questions the desirability of this procedure, especially in the adoption of children who are past infancy and suggests that it encourages adopting parents to consider independent placements in their own best interests.

Also of specific relevance to adoptive parents, is the discussion of the provision on religion which was upheld by the 1970 Act. Basically, this means that adoptive parents are still required to be of the same religion as the child's natural parents. Again, as has also been pointed out by other authors, this automatically eliminates a number of prospective adoptive couples.

A problem that has long plagued adoptive parents, that of the natural parent withdrawing consent after the child has been placed in the adoptive parents' home, is discussed by Katz (1971). Most state laws and the Uniform Adoption Act do not allow the withdrawal of consent after the final adoption decree but, in many jurisdictions, this can occur during the period of time that elapses after placement and

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before the decree is issued. In some states, such as Florida and Illinois, consent is absolutely irrevocable unless it was given under conditions of fraud or duress. In Michigan, on the other hand, parental consent is absolutely revocable until the final decree. Most states, however, allow for revoking of consent at the court's discretion. This is in accord with the Revised Uniform Adoption Act which allows revoking of consent before the final decree if the court approves and considers it to be in the child's best interests. This was the situation in New York, where the natural mother's petition for the return of Baby Lenore was upheld. Later, after the adoptive parents took the child to Florida, the Florida statute upheld the adoptive parents' claim.

As a result of the Baby Lenore case, a number of reforms have been suggested and are discussed by this author. He includes a reminder to adopting parents, that they have the right to accurate information on the legal status of the child they are adopting, prior to placement in their home.

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Bea Lampiris

MEDICAL CONSIDERATIONS IN ADOPTIONS

No one can understand better the concerns of new parents for their newborn than other new parents. If this is true for the natural parents of a child, it is all the more pertinent for parents who are about to adopt an infant or child previously unknown to them.

In a recent article in Children Today, Dr. William B. Carey, a pediatrician in Media, Pennsylvania, and father of three adopted children, addresses himself to some important medical aspects of the adoption process.

> Largely neglected has been discussion of the physical aspects of the children. This is partly the result of a popular tendency to underestimate constitutional factors in children and also because few pediatricians, who are familiar with the concern all parents show for the health of their children, have addressed their writings to adoptive parents. . . . I offer here my suggestions for helping parents understand the medical aspects of the adoption process. (page 10)

Basically, Dr. Carey believes that the adopting couple need information about the medical history of the natural father and mother as much as they need an evaluative study of themselves. Too often even the professional social workers may omit gathering and reporting the facts pertaining to the health background of the biological parents and grandparents. But with or without such information, the adoptive parents will need some means by which to properly evaluate both the child and the medical history; and this is where the physician must assume a prominent role.

Risks of Adopting--What are the questions and concerns adoptive parents have? First, there is the mistaken belief that "the risk of receiving a damaged child is too great . . . . This fear is not justified by the facts" (page 11). While no precise figures are available for the incidence of congenital abnormalities in the general population, it has been estimated that approximately 7 or 8 percent of all children have a congenital defect. About half of these abnormalities are moderately or severely handicapping, such as cleft palate, club foot or mongolism. Because 80 percent of congenital conditions are detected by six months of age (50 percent while the child is in the newborn nursery) and virtually all abnormalities are known by the time the child is one year old, the chances of adopting a handicapped child are quite slim.

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> If the child has been adequately examined in the newborn nursery, there is only an approximate one to two percent chance that a moderate to severe abnormality has not yet been detected. By the time the child is six months old, that percentage has dropped to about half of one percent. (page 11)

However, the adoptive parents do incur some risk. For example, there are three types of problems which can escape early discovery: (1) abnormalities of internal organs, such as those involving the urinary tract or biochemical disorders such as diabetes; (2) degenerative diseases which do not become apparent until later in life, like muscular dystrophy; and (3) some forms of mental retardation and brain malfunction. To help adoptive parents make their decision, "a thorough examination of the child and an accurate report of the findings must be made available to them (page 12).

Evaluating the Findings--Given the most ideal situation, that is, one in which specific information about the physical and mental health of the biological family is presented, how do the adopting parents assess the hereditary background of a child? Assistance lies in the cooperation of several specialists. As stated above, the social worker and any examining physician must provide detailed information which is at their disposal. If the situation further warrants, the services of a consulting geneticist can be obtained (for example, in the case of consanquinity of the child's natural parents). A careful history of the mother's pregnancy may reveal complications such as toxemia, rubella infection, drug abuse, excessive x-ray exposure or difficulties in delivery which may necessitate a neurological examination of the child as a precautionary measure. In addition, most hospitals require the Apgar test for newborns which rates pulse, appearance, activity, grimace, and respiration. It also describes any complications such as convulsions or a need for oxygen observed during the nursery period. A psychologist or pediatrician specially trained in the developmental appraisal of infants and children can also be called in for an opinion in a particular case. In other words, a number of trained professionals are available to work either directly with the adoptive parents or their family physician in helping all involved to make an informed, competent decision about adopting all types of infants and children.

In conclusion, Dr. Carey's article leaves the reader with a clearcut need to support the adoptive parents in their concerns about the health background of their child-to-be. He laments the fact that "agencies, physicians and lawyers involved in processing adoptions often seem to be unaware of, or indifferent to . . ." (page 14) the great disadvantage to which the child and the parents are put when significant medical information is not communicated. The adoptive parents should never allow reluctance on the part of any agency or intermediary to deter them from pursuing information. Preparation for adoptive parenthood can be a helpful and guiding experience or it can be anxiety-ridden and disappointing. Having the medical background properly transmitted, discussed and evaluated is one of the steps in a successful, confidence-producing adoption process.

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THEME REPORT

Judith C. Bansavage, Ph.D.

ADOPTION - THE SEALED RECORD - PSYCHOLOGICAL ISSUES*

The three members of the adoption triable--adoptee, birth parents and adoptive parents--are caught up in a variety of emotional problems. Adoption is a difficult area of research because of the legal statutes to protect anonymity, confidentiality and privacy. Dr. Arthur D. Sorosky, clinical assistant professor of psychiatry at the Center for the Health Sciences, the University of California at Los Angeles, reports on some of the issues. His investigation is based on interviews, review of the literature and from group sessions attended by adoptive parents. Dr. Sorosky is predicting that the sealed record will be tested in the courts as a civil rights issue and explains the need for a re-evaluation of the sealed record.

Natural parents, who responded to a newspaper appeal to participate in the study, express feelings and attitudes that imply that giving a child for adoption is an indelible, traumatic experience. The majority express concern for the child and a willingness to help without intruding upon or disrupting the lives of the child or the adoptive parents.

Adoptive parents "seem to bear an irreversible scar-infertility and its psychologic sequelae and tend to be overprotective." They are fearful least liberalized sealed record laws would lead to a loss of the adopted child to the birth parents. While adoptive parents may be empathetic to the concerns of the child and birth parents, they may have a fear of failure as parents and may have to deal with feelings of rejection or ingratitude.

All adoptees desire background information even when the adoptive relationship is good. There are, however, adoptees who have an obsessive need to search for their birth parents because of neurotic problems or secondary to an emotionally barren relationship with their adoptive parents. Some adoptees are perpetual searchers, always stopping short of reunion. It is the search itself and the associated fantasies that have significance. There are adolescent adoptees who threaten to undertake a search for birth parents. This is seen as typical adolescent acting out and the intense fear or anger with which the adoptive parents over-react serves to reinforce the child's manipulative behavior.

It is conceivable that the older literature is no longer applicable to the younger adoptive parents who have been subjected to a more intensive screening of personality traits and motivations for adoption. This trend is already being felt as a result of readily available contraceptive measures, liberalization of abortion laws and an increasing proclivity for unwed mothers to keep their own children. Thus, we are likely to see an increase once again in "black market," independent adoptions and more utilization of artificial insemination as the numbers of children available for adoption decline. These changes are all likely to make our current adoptive psychology become obsolete.

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*Abstracted from an article in Frontiers of Psychiatry. Publication of Roche Laboratories, June 15, 1974.

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Pauline Medice

PARENTAL INTERACTION WITH YOUNG CHILDREN AND ADOPTED CHILDREN CAN ENHANCE COGNITIVE DEVELOPMENT

Each of us in our own way can state emphatically that a child's parents are important. But can we back this statement with specifics, learned through research, or by authoritative statements of leaders in the field of child development? This article intends to renew the basic belief in the importance of a child's first early adult contacts.

The entire realm of parent interaction with children would certainly be too much for one article. Therefore, the author will concentrate on influences parents have related to cognitive development. Equally important are the social, emotional and physical aspects of child development and most certainly these will influence intellectual development.

When enumerating the developmental steps of a young child, Havighurst (1) states the tasks of infancy and early childhood as follows: learning to walk; to take solid foods; to talk; to control elimination of body wastes; to distinguish right and wrong and begin to develop a conscience; and to distinguish sex differences. In addition to all of these, the child must also form concepts and learn language to describe social and physical reality and get ready to read.

When does a child begin concept formation and when does a child get ready to read? Possibly he begins at age two, more likely at age three, four, or five. This is certainly not the beginning says Yarrow and others (12) in a study that looked at a range of variation in experiences of five- to six-month-old infants. A sampling technique in the infant's home was used to analyze inanimate environment in terms of variety, responsiveness and complexity. Results on these three measures showed significant relationships with the cognitive-motivational variable and with fine motor skills. The authors used motivation to refer to clearly specified behaviors, such as reaching persistently for objects, attempting to have an effect on and elicit responses from objects, and showing preferential attention to and manipulation of novel objects. These behaviors were considered expressions of the infant's desire to assimilate, to learn about, and to master the environment. This study then helps support the Province and Lipton (5) research which accentuates that depriving environments may be more detrimental to motivational functions than to specific emerging skills.

Further emphasizing the fact that mother-child interaction is important, Lewis and Goldberg (2) formulated a "generalized expectancy model." This model

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emphasizes the role of consistent mother-infant interaction so that the child forms the belief that he can affect his environment, and bring about reinforcement of his actions. Watson (11) speaks of the importance of consistency among young infant-adult interaction as a precondition for later learning. The common thread in these formulations is the infant--an information processing organism--initiating transactions with the environment and in turn being influenced by these transactions.

It is likely that the infant's orientation to objects and to people very early becomes part of a feedback system with the environment. His smiling, vocalizing, and reaching out to people; his visually attending to and manipulating objects tend to be self-reinforcing and thus, to some extent, self-perpetuating. These behaviors become part of a system of reciprocal interactions which may characterize a given infant's transactions with the environment over a long period of time. This orientation to the world may be more persistent through life and a more significant characteristic of the young child than any specific cognitive ability.

This impact for educational advantage begins so young and continues for the child during his formative years. However, all is not as easy as it seems for parental attitudes seem to affect the amount and quality of early adult-infant interaction. In looking at social class and infant-mother interaction, Tulkin (10) studies the relation between child-rearing attitudes and parental behavior. He found that child-rearing attitudes are associated with the manner in which mothers relate to their young children. In interviewing several mothers in the working-class who felt they could have little influence over the development of their infants, he found tight control as the basis for child-care. Other authors have also noted that working-class mothers "see themselves as powerless, helpless, and overwhelmed" by their children and "not able to do anything" to affect their development (3). By contrast, Tulkin and Cohler (9) found attitudes of middle-class mothers reflected more moderate control of aggressive impulses, greater encouragement of reciprocity, greater acceptance of emotional complexities involved in child rearing, and greater comfort in perceiving and meeting a baby's physical needs. These studies suggest that the way the mother feels about the infant is related to the care the child receives.

Regardless of parental attitudes, Swick and Willis (8) feel performance of the parents in terms of the kind of behavior they present to the child is more important than any other learning experience in which the child might become involved. And Pollar, Hubbard and Salt (4) feel the best nursery and infant schools are unlikely to be able to compensate for disadvantages which derives from the first two years of a child's life. In the realm of educational implications, this explains that the average middle-class families build reading readiness by the age of five or six; provide a rich language diet; and stimulate cognitive development in their young children. Average working-class families read less themselves; read less to their children; and do not use a variety and complexity of language. Therefore, many children come to school lacking in background for the experience.

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Some interesting findings concerning children in good adoptive homes were elaborated by Skeels and Harms (6). The natural parents were either mentally retarded or of very low socio-economic status. Mental retardation in the children "with known inferior histories" who were placed in adoptive homes in infancy was no greater than that of a random sample of the overall population and the frequency of superior intelligence was somewhat greater than would be expected. Skodak and Skeels (7) also reported a twenty point IQ difference between adopted children and their natural mothers.

Accumulating research on parent behavior and child development now suggests the need to develop a whole-life perspective on education which recognizes the major educational role of parents. Present-day knowledge of child development tells us that the child develops as a function of reciprocal interaction with those who care for him. There should be nothing so vital and compelling to all concerned as the need of a young child for the care and attention of his elders.

See REFERENCES on next page

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EXPRESSIVE ART THERAPY

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CREATIVENESS COMES FROM WITHIN

To be creative is to modify one's relationship with the reality in which one lives. The impulse for such modification arises when there is some disparity between one's wishes and the experiencing of reality. The threshold of difference between reality and complete gratification evokes inner strivings and also response to what is available outside the self. A simple example of the genesis of creativity can be observed in the active oral play of infants at the breast or with the bottle. As the baby's energies are not entirely absorbed by the process of obtaining the food needed for his biological integrity, one can easily observe little movements of tongue and lips by which the child amplifies the nursing experience, thus actively creating with his own energies new meanings in the contact between himself and the mother's breast or the bottle that are outside himself. These early creations often have rhythm and pattern as the complex movements of the dance have. But they are characterized by active striving toward augmented gratification in the contact between the infant and that which is available to him in the environment. In breast-fed infants these activities are clearly experienced by the mother; the mothers of bottle-fed infants are able to feel the rhythmic movements of the bottle as the baby trills his tongue against the nipple. Thus, even in its early forms creativity modifies the experience of those to whom the creative outcome is available through their sensibilities. In this sense creativity is a form of communication.

I mention these simple beginnings to you so that we may include in our thinking about the creative experiences of older children the basic wellsprings of all human creativity. By the time a child is able to move about at his own initiative his environment has become complex and he himself has grown and developed new capacities. He has new needs and wishes; his creativeness has become varied in mode. He is often intensely absorbed in his efforts to give innovative meaning to his contacts with things and people. His biological needs are still clearly expressed in his attempts to augment his experience; these needs tend to direct his perception of his environment. For example, he is still intensely interested in the things that go into his mouth and when left to his own devices use these things creatively to augment his pleasure in them. If left alone for even a moment with a bowl of cereal on his high chair tray the toddler will put his hand into it, put his hand into his mouth, but also put the cereal on the high chair tray and rub his hands through it much as he will rub the finger paint when he is older. Yet there is a difference. Provided that his mother warmly but firmly sets limits on his smearing with such things and offers him something for play that she is willing for him to use, such as a little piece of pie or cookie dough, the child will begin to try to discriminate between what his mother approves and what she disapproves. He will begin to direct his contacts with smearable materials, putting them into containers and taking them out again; he is taking new steps in creativity--channelling both his own energies and giving new form to materials in his world.

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In the past few years, so much emphasis has been put on providing freedom for the creating of children that it is easy to lose sight of the function of limits set by the loving responsible adult in motivating the child's striving to bridge the gap between his impulses and the wishes of his loved adults. The mother's offering of cookie or pie dough or sand as a substitute for oatmeal supports the child's efforts toward "making something with what is available to him." Older children ultimately use the edge of a paper, a sandbox, a clayboard, to define their own limits and to impose form on the material. Mrs. Judith Rubin gives blind children cookie sheets or jelly roll pans for their finger painting so that they can experience limits. Such limits are an essential component of the motivation for creating. The limits provided by the adult evoke the child's recognition of the reality outside himself, limits define the difference between the child's impulses and the wishes of others. Loving and the wish to be loved support the child's efforts to be true to himself and at the same time give gratification to others or avoid their displeasure.

The child tends to explore substitute modes of fulfilling his wishes in order to receive his loving relationships with adults--only if his efforts toward new modes are not denied to him.

As a little child Fred Rogers, the television artist and composer of songs, was not permitted direct expression of anger in tantrums or aggressive outbursts against other people or things, but he was permitted free access to the family piano. When he was angry he went to the piano and pounded out his anger there. By the age of five he had learned to play melodies with a heavy staccato beat when he was angry. His sadness also came to be expressed through the use of the piano. Little by little he came to create melody patterns that served to channel his feelings. These beginnings lie deep at the source of his current creation of songs about the feelings of children. That creativity expresses the child's strivings to be true to his inner feelings and at the same time to develop good relationships with the reality outside himself, is best perceived when one observes a child's responses in a sustained way over time.

For years I worked with a little girl, fragile of build who was blind in one eye. Maureen, like every four-year-old girl, had longings to be visually attractive to others--especially to her daddy. Because of her visual handicap she felt unsure that she could be attractive. She knew the story of Sleeping Beauty well; it had special meaning for her because of the closed eyes of the sleeping princess. In my office the little dolls became accessories of her creative work on her problem. She identified one of the dolls as "Beauty" and over many weeks created poignant dramas about "Beauty's" deprivations and sleeps, and then themes of hope about "Beauty's" active problem solving. She ultimately gave "Beauty" the identity of a nurse who would care for the disabilities of babies and children. "Beauty" finally became the romantic love object of the doctor who also took care of children's disabilities. "Beauty" became a beautiful bride, and also a mother, but the child's fears of death were expressed by taking "Beauty" and her baby away to Heaven where she became the "Queen of Heaven." The separation of "Beauty" and the doctor was a sad theme, but was resolved by the "Queen of Heaven's" coming to take the doctor to Heaven with her; where the baby, "Beauty," and the father were joyously happy.

For this little girl drama was her first creative mode, but later painting became a second way of work. Of all of her graphic representations, a tree was most frequent. Her trees had carefully drawn complex root structures; the roots tended to be near a stream (that provided nurture for the tree). She covered the roots by an overlay of brown and green paint. Her comment to me was "Only you and me know they're under there." These representations dealt with a period when Maureen was striving to develop an image of herself as being strong and having deep inner resources or roots. At one time, she was angry with the art teacher in her school who offered the children the option of drawing whatever they liked, and then when Maureen had begun the tree that at that time was such an intense preoccupation, the teacher had said "Oh Maureen, don't draw a tree; everyone draws trees." Maureen had crumpled up the tree picture and indignantly began another drawing using the colors of her trees, but converting it into a representation of a pretty girl, and said triumphantly, "The teacher didn't know I had drawn it anyhow."

One creative mode is not the best suited for all children. If flexible alternatives are offered to children they will let us know what media are best suited to their work. Some children, like Maureen, have persistent creative modes that they adapt to work on many themes important to them, but other children seem to find some modes best suited to certain periods of development or as accessories of work on a particular problem. Other forms of expression may seem to fit other issues.

Children often discover the creative modes of the adult available to them, and for a period of time work in the adult's preferred medium as though by so doing they support their own creative energies by identifying with those of the adult. It is, however, important that the adult recognizes this possibility and provides a situation in which children can explore other possibilities that may be more natural for them than the teacher's preferred mode.

The creativity of adults who work with children is, however, important in the significance that the expressive arts have for children. In the first place, the adult's own creative experience tends to foster empathy with the meaning of the child's creative play. Such empathy need not be verbalized, but may be communicated to the child by subtle means, such as the teacher's attentiveness to the child's work, or her facial expression, body posture; her internal reactions that are operant in the relationship between the adult and child. Verbal comment may be helpful provided that what is said deals with the real value of the process rather than with just the esthetic or technical success of the outcome as the teacher perceives it. The expression of sincere pleasure in the child's product has its place, but is less important than real appreciation, either verbal or non-verbal, of the meaning the process has for the child.

The presence of the adult seems important as a support of the child's striving to make something of his experience.

Without the availability of the teacher, the children cannot maintain themselves in creative channelling of finger paints, water colors, blocks, or other creative media, but tend to regress in using blocks as missiles of aggression. Even with much older children, the adult worker is essential

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to their striving to develop innovative life solutions through creative experience. The teacher receives the child's communication, supports the child's imaginative experimentation, and provides structure within which the child can feel confident of his capacities for self direction.

Through expressive arts, children can progressively develop their inner resources--their understanding of themselves and the real world; their personality patterns, retaining the full range of human feelings that contribute the child's self realization, as well as to the experience of those who are related to the child in some way.

Plays planned by the teacher, art projects or dances initiated by adults, have a place in the experience of children, but true creativity comes from within the child in response to his contacts with the world in which he lives. The term "expressive arts" implies that what the child creates comes from within of the child's thoughts and feelings as he discovers his own unique potentialities and his humanness that he shares with all other persons. Given time and accessories of creative activities, the child will work out his own expression and yet his play or work (as you choose to designate it) will have maximal value for his development only when there is a concerned and emphatic adult available to him. This gives the identity of the teacher who provides time and accessories for expressive arts great significance.

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Juergen Homann, M.D.

CREATIVE MODALITIES IN CLINICAL WORK WITH CHILDREN

In contrast to clinical work with adults characterized by its emphasis on verbalization ("talking therapy"), therapeutic work with children requires skill and experience in non-verbal and symbolic communication. Play therapy is the natural (for the young child) context in which worries and conflicts can be externalized, shared, as well as mastered. If we visualize for a moment any of the familiar play sequences of young children, it is easy to detect essential elements of creative modalities. It may involve the enactment of an exciting phantasy (dramatic play)--body movement and postures may express feelings (movement and dance) or with the help of magic markers, finger paints, or clay, visual images can grow out of feelings, phantasies, and memories (art). If relatively unstructured free play experiences seem natural for the preschool and early latency child, the somewhat older child will feel awkward; "just playing" is frequently experienced as "baby stuff." Yet talking about worries, feelings, and experiences seem artificial as well. It is this age group, from about eight to twelve years, which utilizes the slightly more structured (compared to free play) creative and highly symbolic communication of art, drama, and movement (dance).

A variety of clinically useful information becomes available to the therapist and the child. For example, in the semi-structured task of "making a picture about all the people in the family doing something," the child begins to visualize his perception and feelings about family members as they relate to each other and to himself. The use of colors may relate to affective and mood experiences. The child's choice of material may give us a clue about his expressive capacities (pencil and erasers are demanded by youngsters unsure and critical about their products and themselves), and the child's reactions (often verbalized) to his painting frequently relates to feelings about himself. The "I can't draw youngster" shares with us the unhappiness created by rigid internal control mechanisms.

Drama just as art may take many forms in the therapeutic context. Two of the more widely known modalities are the "Mutual Story-Telling Technique"[1] and creating a puppet show. Most children are easily involved with puppets. In this experience, several sensory modalities are involved: (in addition to the creative experience of making up the show) visual image of the puppet, feeling of the "King's robe," or the "little cat's fur," as well as auditory and kinesthetic sensation during the play, as compared to the mainly one sensory experience in the mutual storytelling technique. Whether such difference is related to our experience that it seems easier to engage the child in puppetry than in mutual storytelling, remains an open but interesting speculation.

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The therapeutic potential of the creative arts modalities can be characterized as follows: (1) Developing a positive relationship between therapist and child. Since the therapist has these additional means of communicating with the child, the therapeutic situation seems less awkward and artificial as compared, let us say, to the situation in which verbal transaction are the main ones deployed. (2) The child can learn additional means of expressing feelings, phantasies, and worries. This aspect is especially important for children who seem restricted and rigid in their expressive capacities and as a result have limited interaction with others, become or remain relatively isolated and thus restricted in their further development. (3) Over and beyond expression of feelings and phantasies, creative modalities provide a context in which feeling conflicts can be resolved in a way that seems particularly suitable to the child's developmental capacities. The therapist here functions as a facilitator, not a problem solver.

Finally, it should also be mentioned that creative modalities have proven most productive in evaluation and intervention with family groups as well as other therapy groups, although more detailed descriptions of these therapeutic models would go beyond the scope of this paper.

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Ideas expressed in this paper grew out of my most fruitful work experience with Dr. Irwin, Mrs. Rubin, and Mrs. Bernstein at the Pittsburgh Child Guidance Center.

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DRAMA THERAPY

Eleanor Irwin

> "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean--neither more nor less."
>
> "The question is," said Alice, "whether you can make words mean so many different things."

Well, as Alice says, sometimes words do sound "pretty, but rather hard to understand." Take the jargon of drama, for example. There's "formal" drama (i.e., "plays," children's theatre, participatory theatre); "informal" drama (i.e., dramatic play, creative dramatics, role play or sociodrama, and dramakinetics); and, "therapeutic" drama (i.e., psychodrama and drama therapy). Well, to quote Humpty Dumpty, "there are plenty of hard words there."

There are, however, a number of ways to decipher the drama jabberwocky. One way is talking about the purpose or goal of the dramatic activity, whether for entertainment (as in formal theatre), for education and prevention (as in informal drama), or for therapy (as in psychodrama and drama therapy).

"That's a great deal to make one word mean," said Alice in a thoughtful tone. Precisely because words do mean different things to different people, I'd like to discuss what some of the above words mean to me, and then describe the many overlaps and intertwining between drama in education and prevention, and drama in therapy.

DRAMATIC PLAY

Most kids like to take roles and pretend; they enjoy becoming involved in make-believe play that may imitate reality, yet not be "real." When the child is three, four or five years old, in fact, purposeful imitation is one of his chief ways of learning, and of differentiating between himself and others. At this age, children like to play house and horsy; doctor and dinosaur; policeman and airplane. Some of the hallmarks of dramatic play include its unrehearsed, spontaneous nature, its relatively plotless quality, as the players make-it-up-as-they-go-along. The artlessness of it, in fact, belies its serious purpose and disguises the nature of the purposeful learning taking place. The content of spontaneous dramatic play may be focussed around family members and the child's relationships to them and his surroundings; the play may be fueled by the child's inner wishes, curiosities, wonderings, fears and fantasies, as each player follows his/her own internal "script."

Sometimes children's dramatic play is based on reality, sometimes on the fantasies that are fed by real-life situations. At times kids play freely and contentedly; other times their play is suddenly, inexplicably interrupted in a puzzling way:

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Four year-old Becky and three-and-a-half-year-old Lisa had been playing quietly in the doll corner for some time. "Pretend you're coming home with your baby from the h'spital, okay, Lisa?" Becky asked.

Lisa's face began to pucker, then she began to whimper and when the teacher reached her, she was sobbing loudly. Through gasps and tears she cried, "My arm ... an' ... an' she wanna' cut it off."

Fortunately, the teacher was able to understand Lisa's sudden inability to continue to play. Several months earlier Lisa had broken her arm and had been in the hospital. When her cast was removed with the surgical saw, she experienced tremendous fright, afraid her arm would be cut off.

Becky's reference was to mother-new baby hospital play; Lisa's association, however, was quite different and almost immobilizing in its intensity.

CREATIVE DRAMATICS

Is an almost too-broad term that encompasses many forms of spontaneous drama, including guided dramatic play, puppetry, movement-drama, improvisations, story dramatizations, and role play. Because latency children (roughly 6-12 years) are more structured and reality-oriented than preschoolers, their dramatic play is more structured also. There's more emphasis upon plot and form, and greater peer pressure to work together on issues of common interest. Of the group finds "mutual themes" which relate to their shared feelings:

A group of fifteen 8-12 year-old children had gathered for an after-school creative dramatics class. One child began to complain bitterly about having to stay after school because "Mean Martha" (the teacher) had given them a long assignment and had been critical of her work. The others joined in a chorus of complaints about "Mean Martha." Eventually this led to a discussion of adult behaviors which the children liked and disliked. Two thoughtful improvisations resulted from this: "The Perfect Parents" and "The Imperfect Parents."

These children, like most children their age, were experiencing feelings of disillusionment with their parents and other adults, and had fantasies of finding a "perfect family" which would love and appreciate them. Their stories had a kind of fairy tale quality that is typical of this age group.

ROLE PLAY

In role play, the story to be played out is quite structured and its purpose is to achieve specific cognitive or affective goals, i.e., to clarify behaviors, learn new skills, change attitudes, solve problems, specify areas of agreement or disagreement, increase sensitivity or awareness of others' needs and viewpoints, etc. The activity is usually task-oriented, as the leader presents the beginning of a role-play situation, asks volunteers to play the

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various roles, and then suggests specific tasks for both participants and audience. Role play is often a group problem solving effort.

THERAPEUTIC DRAMA

Both psychodrama and drama therapy are alike in that they are psychotherapeutic techniques used in a planned sequential way to bring about changes in personality and behavior. The two approaches differ, however, in procedure, goals, direction and orientation. In psychodrama, the protagonist (main character) explores his conflicts in an individual drama, using other group members to portray roles as needed (i.e., they function as "auxiliary egos" for him). The director is active in leading the psychodrama, in helping the protagonist to explore his areas of difficulty, in clarifying and expressing feelings, and/or in exploring alternative behaviors. Many therapists use psychodrama as a treatment modality with disturbed children, but it's been my experience that while some of the techniques are helpful, psychodrama as a treatment modality per se is not particularly effective. There are, however, some psychodramatic techiques which are quite useful with both "regular" and "disturbed" children, as illustrated, for example, by Janet Lederman in Anger in the Rocking Chair. For me, psychodrama with children is too direct (and directive), verbal, structured, reality and action oriented to help youngsters to truly work through their multiple conflicting feelings. Similarly, while adults might have the ego strength, psychic distance and verbal skills to confront their problems directly through psychodrama, children do not. Rather, children seem to need the protection and disguise of fantasy as they gain courage to look at themselves and their difficulties. Therefore, drama therapy, which includes improvisation, puppetry, movement and mask and mime work, seems to allow greater freedom and flexibility of style for both therapist and child, while allowing the latter to move at his own pace and explore, in his own time and way, his inner world of feelings.

OVERLAPS: DRAMA IN EDUCATION AND DRAMA IN THERAPY

There are many similarities in work with children in the therapy room as well as in the classroom, where dramatic activities can help children deal with the normal stresses and strains of life, as well as helping them to think, explore, investigate, fantasize and problem solve. Some of them include: environment, materials, interaction and expressive activities.

ENVIRONMENT

Most people learn best and function most effectively in a setting that is psychically safe; where they feel accepted, understood, and have a feeling of belonging. Whether in a family, classroom, or therapy room, children feel freer to explore the uniqueness of their feelings and thoughts in an atmosphere where there is a climate of respect and caring; an absence of criticism and shame. An accepting, facilitating environment encourages openness and exploration, while a tension-filled setting reinforces defensiveness and suspicion, which is antithetical to growth and development.

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MATERIALS ...

Help, of course. A prop box filled with intriguing materials invites a child to explore and define himself in play. Additionally, materials have certain qualities in and of themselves which stimulate certain responses and behaviors:

... as a devil puppet invites a different response from a king puppet
... as a stethescope invites a different response from a policeman's hat
... and, as a plain piece of material encourages multiple explorations and possibilities, serving as a cape, blanket, or covering for a "spook" or whatever the myriad need of the moment might be.

The degree of structure and specificity of the materials, therefore, can determine the direction of play and enhance or regard its elaboration. Materials can invite one to build a fantasy world or a real world; encourage one to work alone or with others; emphasize boundaries or the lack of them; feel alive and exhuberant, or quiet and contemplative. A variety (not necessarily a large amount) of material for dramatic play can be a "pivot" for the child, propelling him into play, spanning the boundaries between the real and the imagined.

INTERACTION

It is perhaps in the interaction between the adult and the child that therapeutic or non-therapeutic behaviors most often occur, regardless of setting. Adults are therapeutic when they:

... care about what the child says
... listen and try to understand the child's spoken as well as his unspoken messages
... try to understand what life is like for the child and how that child experiences his environment
... remember what the child says and does, perhaps even keeping a journal of his comments and behaviors.

Young children, especially, know that people care for them by the things they do: like helping the child to define himself through his activities; valuing his words, stories and products; and maybe even helping the child to prepare his own reader, full of stories, songs, poems and original art work. Adults function therapeutically when they observe carefully, question sensitively, and show that they respect the child's uniqueness, rights, and boundaries.

When adults share and appreciate the child's needs and interests, a circular reaction results. When the child feels understood, he, in turn, responds to and identifies with the goals, interests and values of the adult. When the child feels appreciated and understood, (s)he has a reservoir of good feeling about himself which helps him to cope more effectively with life's inevitable stresses, and when frustrations outnumber gratifications. These things seem to hold true in the child's interactions with parents, teachers, therapists and, in fact, in all human interactions.

DRAMATIC PLAY AND OTHER EXPRESSIVE ACTIVITIES

Expressive activities are particularly well suited in helping children to explore their wishes, feelings, and ideas, whether in the classroom or the

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therapy room. In play, children often experience the gratification of wishes denied to them in real life. It helps to have an outlet like dramatic play, for example, for the socially acceptable as well as the unacceptable feelings, and the "make-believe" element makes this permissible and safe. The child may, therefore, express the wish to be big and strong or to be little and helpless; to hurt, be hurt, or to repair the hurt; to make a powerful noise or to be quiet; to control or be controlled; to be defiant or compliant. Motivated by their common aims, children attempt to gratify their wishes in play and sublimate and master them. Often as a child expresses and channels his feelings in play, he feels more in control of them and of himself; in gaining control of his feelings, he is better able to control the play and the environment. For little children, who often feel controlled by powerful adults, it is immensely gratifying for them to feel their impact on others.

WHEN CHILDREN CAN'T PLAY

Teachers know that all children occasionally have times when they are unhappy, disappointed, or angry, and are therefore too preoccupied to channel their energies into learning. Often teachers are able to help children to find safe ways of expressing these feelings in play.

Some children, however, experience more than an occasional inability to play and truly lack the skills to be able to involve themselves in meaningful, satisfying play experiences. Such children often flit from toy to toy; their play is disorganized and diffuse, reflecting their inability to channel their energies in symbolic activities. With such children, the teacher can serve as a role model and teach play skills, intervening in the child's play in order to help him to learn more appropriate play patterns. The studies of Smilansky, El'Konin, Feitelson and Ross, and others, indicate that play skills can be taught, and that modelling play behaviors is essential in order for the child to learn such skills. My own work with speech handicapped and emotionally disturbed children has also indicated that adults can serve as role models to teach play and language skills.

In this regard, creative dramatics (or guided dramatic play), with its emphasis on spontaneity of behavior, sequence of actions, and the multiple role modelling opportunities within it, seems to be a particularly feasible way of helping children to learn play skills. This means, of course, that the adult must follow the child's lead, being careful not to contaminate the play and thus alter the content.

Some children, however, seem to play the same scary themes in repetitive ways without being able to master their anxiety. The content of their play does not change over time, nor does the child seem to be able to use the cathartic opportunities within the play to work toward mastery of his impulses. It may be, therefore, that the empathic support (or, the ego support) of the teacher may not be enough, and referral for psychotherapeutic help may be indicated. In such an event, the therapist may well use more play, supplemented by skillful intervention, and work with the child, trying to understand his symbolic communications, and thus free up his energies for positive growth.

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In summary, teachers and therapists both function therapeutically when they establish environments conducive to learning, growing, and exploring the outer as well as the inner world; when they respect the child's feelings, his internal rhythms and his ideas; and, when they facilitate expressive play opportunities. Such adults show by their actions that they value creative exploration and the remarkable uniqueness of human functioning. As Winnicott has said, "It is in playing and only in playing that the individual child or adult is able to be creative and use the whole personality, and it is only in being creative that the individual discovers the self."

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Judith A. Rubin

ART FOR YOUNG CHILDREN'S GROWING: DIAGNOSIS AND THERAPY IN THE CLASSROOM

While it may sound strange to use clinical terminology to describe what a preschool teacher can do, perhaps a translation from "diagnosis" to "understanding" and from "therapy" to "helping" will clarify. The issue then becomes how the teacher can both understand children's growing and help to facilitate it through art. This idea has been popular in the past, but with less than happy results:

> The tendency of some teachers to try to interpret the symbols in a child's work is probably one of the most devastating practices conceivable. Teachers are not analysts.[1]

> The misuse of the psychological approach has taken its most serious toll in the application of pseudo-therapy and the homespun analyst. . . . Many teachers have probed into the backgrounds of children and have classified them according to some diagnosis they have made of their art work. In some cases, only one symbol is sufficient evidence for the teacher to classify a child's difficulty, supported by some clichés about the home situation which she may have read in a book.[2]

If both early childhood specialists[1] and art educators[2] were uneasy about inappropriate psychologizing in the classroom, why introduce once again the notion that diagnosis and therapy (understanding and helping) belong there? I think because the basic ideas were sound, sadly misused and abused, but still able to be actualized in a healthy and realistic way.

Indeed, no one is in a better position to both understand and help children through art than the classroom teacher. Unlike the mother, she is likely to have appropriate space and materials for work and a homogeneous age group. Unlike the therapist in the clinic or the specialist teacher at the crafts center, she knows the child over time both extensively and intensively. The child care work in a residential institution is in a similarly advantageous position.

If you accept the proposition that art can be a useful way to understand and to help growing children, you might then want to consider the following conditions as facilitating the possibility of these occurring in the classroom.

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FIGURE 1

FIGURE 2

Make Personally Meaningful Work Possible

1. Create an atmosphere which is relaxed, yet orderly; in which time and space and limits are clear and predictable. Only within such a secure setting can a child be truly creative. Children need, in other words, a "framework for freedom."

2. Have basic media always available for "urgent" needs for expression, e.g., make "spontaneous" work truly possible. During "free play," make sure that materials for drawing, painting, modeling, and constructing are available; and that they may be used with no restriction on subject or style.

3. Be flexible enough to allow for use of art media at any time when a child desires it as a way of dealing with immediate concerns, especially as a way of coping with traumatic experiences. Figure 1 was done by a three-year-old who had been frightened because she got los on the way home. It is a picture of "A man crying for his Mommy 'cause he got lost in the dark. He can't find his way home 'cause it's too dark and he's afraid."

FIGURE 3

FIGURE 4

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FIGURE 5

FIGURE 6

4. Provide sufficient choice of media that a child may utilize that one which he finds most appropriate for expression of a particular idea at a particular time. Make sure basic materials are available over time, so that individuals may practice with them and achieve sufficient mastery to be able to use them to externalize their feelings effectively. If Andy had not practiced so much with felt tip markers, he probably could not have drawn his powerful "Batman" in such a potent wish-fulfilling way. (Figure 2)

5. Provide sufficient choice of surfaces and locations that a child may have social stimulation, the support of his peers; or, if he wishes, a quiet privacy. Figure 3 shows a humorous attack on adult authority done by a girl who sat next to a boy who was also drawing a funny picture of the teacher in an after-school group. Sitting together, they derived enough support and security from each other to be able to risk such angry, naughty pictures. Figure 1, on the other hand, was done by herself in the corner by a girl who was so upset that she needed to be alone to concentrate, to cool down, and perhaps to create.

FIGURE 7a

FIGURE 7b

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6. Respect the child's autonomy, by making independent work truly possible, from procuring materials to deciding what to do, to not intruding during the working process, to responding to requests for help by helping him to help himself, to listening respectfully to what he has to say about both process and product.

Illuminate Important Concerns

7. Provide stimulation for exploration of ideas and feelings around shared group needs, through experiences involving media or themes related to the current concerns of most of the children. Figure 4 is a picture of "A Mommy with a Baby in her Tummy," one of several done in a kindergarten class in response to the teacher's suggestion of a picture about babies before they're born, a vocal concern of the youngsters at that time. The medium was the key tool; on the other hand, when a group of fours explored "how far you could go" with the finger paint in terms of which of three tray sizes they would prefer, a task related to the issues of regression and impulse control with which they were then actively dealing.

8. Help children to deal with normal or atypical stress situations, such as sibling birth, visits to the doctor or hospital, loss of pets or relatives, riots, earthquakes, etc., through creative expression and discussion of the feelings involved. Figure 5 is a picture by a deaf-mute following a visit to the dentist. Her teacher wisely encouraged her to draw about the fearful experience she had just undergone, helping her to gain some symbolic control over and understanding of what had occurred (as well as to discharge her inner tension).

Enter the Child's Frame of Reference

9. Observe, without intruding, all behaviors involved in the creative process. Often the most important "meanings" occur in the process of creating the work, and are not visible in the final product--like the red-brown clay touched but rejected for gray by the black child, or the faces drawn in and wiped out in finger painting, or the extensions squeezed or chopped off in clay modeling, or the sequence of figures drawn in a family portrait, or the portion of the picture over which the child hesitates uncertainly before painting it in.

10. Be alert to what is "noraml" for a particular developmental level, so that an age-typical device is not labeled as a "deviancy." Mixed points of view, for example, are typical of the pre-schematic and schematic stages of graphic development, so that a picture like Figure 6 should be considered appropriate for a six-year-old, not strange or psychologically "significant."

11. Be alert to what is "normal" for a particular child, so that a change in style, especially a regressive one, enables you to guess that the child may be coping with some stress situation. Such was the case with five-year-old, cerebral-palsied Joe, who could draw well-organized human figures, like a clown (Figure 7a) but when asked to draw himself produced a chaotic, disorganized form (7b), saying sadly "the legs got lost in the grass."

12. Be accepting of any and all valid (nondestructive, within-limits) forms of artistic expression; whether neat or messy, pleasant or unpleasant, regressive or progressive. It might not be easy for some teachers to tolerate the raw violence and anxiety of five-year-old Tom's pictures of a man being thrown off a mountain (cover drawing), or a scissors cutting off a brother's nose (inside cover); but it will help Tom immeasurably if his anxiety and his anger can be accepted calmly by an adult, especially in symbolic form.

13. Be sensitive to and available for spontaneous, unsolicited verbalization about his work during or following the process of making it. One preschool teacher was described as working with a child who "often played alone with finger paints or clay":

> When the teacher was able to spend a little time with him, he spoke freely to her of the rich fantasy life through which he was trying to synthesize his experience. For example, while playing with clay, he talked with the teacher about his dreams of "a big giant that sleeps on the floor by the door" and "eats people," about his fantasies of wolves, lions, gorillas, bears, and sharks, bad animals and of ways of restraining the animals. . . . The teacher made no interpretations to Jerry. By her listening and the consistent positiveness of her relationship with him, she implied her empathy for his feelings and the support of her ego resources in his striving.[3]

14. Beware of simplistic, pat "recipes" for deciphering meanings of colors, space usage, forms, or symbols in children's art. Remember that for every child to whom yellow is positive and joyful, there is one like Dibs[4] for whom it represents other feelings like fear, and even a cultural meaning in the negative direction ("yellow" = cowardly). Certainly, the depressive connotations of black for (perhaps) the majority, cannot be assumed to exist for the brown youngster to whom black is and should be beautiful.

15. Remember that the best diagnostic guidebook is the child himself. When his own work deviates markedly from his norm, you can be sure that something is up (though it may be an imitation of his neighbor). This can be seen in the difference between Joey's clown and his self-image (Figure 7), the latter a source of genuine anxiety.

16. In discovering symbolic meanings, the child himself is the very best source. Help the child, through interviewing with open-ended questions (questions that don't suggest or unnecessarily limit the answer) to clarify and to extend his own ideas and fantasies. And don't worry about digging too deeply or misinterpreting a child's work, as long as you let the child define the meaning through his associations, and accept without further pressure his response to your questions. The greater danger is that your own projections and ideas may interfere with your ability to truly observe and hear the child.

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Perhaps the most "therapeutic" thing you can do in a classroom, is to provide a setting in which each child can become himself. First, you will watch and listen, to understand just who that child is, and where he wants to go. Then you will try to help him get there, by overcoming inner and outer roadblocks, and by trulying valuing his own definition of himself in an art form. Then you will, through your understanding and provision of appropriate conditions, be helping him to feel good about his growing mastery of both tools and feelings, his progress on the joyous journey of becoming.

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MUSIC THERAPY

Richard Gray

According to the Careers in Music Therapy brochure issued by the National Association for Music Therapy,[1] Music Therapy is the use of music in the accomplishment of therapeutic aims--the scientific application of music as directed by the therapist in a therapeutic environment to influence changes.

Music therapists sometimes teach music. Their educational background has prepared them to do this when it is an appropriate part of the treatment program. Musical performances by instrumental and vocal groups, participation in the study of music theory, music history and appreciation, all are to be seen in the activities of many music therapists. Persons employed in this field work in psychiatric hospitals, various settings for the mentally retarded, public and private schools for both physically and emotionally handicapped, community mental health centers, correctional programs, and many others.

Because of their training, music therapists are equipped to utilize unusual musical approaches. Leo Muscateve, Registered Music Therapist and past President of NAMT now at the University of Wisconsin in Milwaukee, was responsible for a large music therapy program for many years. He describes using the dropping of a cymbal periodically over a period of weeks to stimulate an initial response from an otherwise very unresponsible individual. This he was able to capitalize on and move on to more complex activities. This certainly would not be characteristically termed either a musical activity or a musical response, but was performed by a skilled music therapist whose extensive experience in many more complex activities did not preclude his thinking of this simple approach that no one else had thought of, which after all proved effective.

Joanne Pasquinelli, R.M.T. at D. T. Watson Home for Crippled Children in Pittsburgh, finds the annual production of an original musical is an excellent vehicle for involving children who need challenge and encouragement in activities to increase their self-confidence, improve muscular coordination, provide opportunity for self express, etc.

Anita Louise Steele, R.M.T. at Cleveland Music School Settlement, works with all kinds of children with handicaps, but in one group of non-verbal preschoolers encourages the singing of very simple phrases about members of the families and progresses gradually to verbalization.

Florence Tyson, R.M.T. at the Music Therapy Center, Inc., in New York, works extensively in music and the other arts with persons referred by private psychiatrists.

Vance Cotter, R.M.T., presently at Battelle Institute in Columbus, Ohio, developed specific procedures for utilizing music preferred by profoundly retarded subjects as contingent reinforcement for accomplishment of specific tasks.

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Carol Bitcon, R.M.T. at Fairview State Hospital in Costa Mesa, California, uses simple roundos, instruments and other materials developed by Carl Orff, for utilization in music education. She finds they stimulate verbalization, creative movement and imagination in children with varying degrees of mental retardation and emotional disturbances.[2]

Nordoff and Robbins,[3] as well as Juliette Alvin,[4] have published extensive descriptions of their wide range of "treatment" of children with emotional disturbances and mental retardation.

These sketches only minimally illustrate a few of the many areas in which music therapists work. Variations on standard types of musical groups are dictated by the limitless variety of physical, emotional, and intellectual handicaps found in rehabilitation settings and schools.

Music therapists can in these senses "treat," with stress being placed on the establishment of meaningful relationships and utilizing the attractiveness of music to motivate persons in the practice of otherwise mundane, but essential, therapeutic activities.

Beyond treatment, the therapist seeks to give to the client the encouragement and skills needed prior to delegating to an individual the responsibility for expressing himself. The arts cannot be considered less essential than verbalization, or the emphasis will be less than adequate. John Dewey says: "If everything could be said by words, there would be no arts."[5] If the persons to be helped could be helped to feel that the arts in their simplest forms can be used to remind them of their creative ability to cope, perhaps they would be more motivated to change. They can permit persons to reveal themselves, express themselves, and begin to experience communicating with and finding structure in an otherwise meaningless, if not hostile world.

An interesting extension of this approach deals with the supposedly healthy public which is unable to see its own need and spends much effort avoiding involvement. It becomes necessary at this point to indicate the continuum existing from simple to complex art, and to suggest that the development of the arts was not simply to fill museums and concert halls, but to function as a means of opening up channels for experiencing being a creative person. This need exists in every person. This cannot be limited to the populations Bernard Farber states we treat as "surplus," such as mentally, physically, intellectually handicapped, etc.

The music therapist at times must deal then with opportunities to encourage and assist persons who would fall into a wide range of categories, some who recognize themselves as handicapped and some who would resist being termed as such, but who are nonetheless unable to visualize themselves as a normally creative person.

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Donna Hallen

USING DANCE IN THE CLASSROOM: AN EXPRESSIVE ARTS APPROACH

BACKGROUND

Dance therapy, as defined by the American Dance Therapy Association (A.D.T.A.), is the planned use of any aspect of dance to aid in the physical and psychic integration of the individual. Various techniques, based on a number of philosophies of movement, find shelter under the umbrella of this broad definition. Dance therapists share a strong conviction that when Marion Chase, who is a dancer, a teacher, and the founder of the A.D.T.A., first approached psychiatric patients through body movement and dance, a new and exciting area of expression and communication was opened. Today, in a variety of institutions, schools, and training groups, dance movement techniques, adapted to the task at hand, provide a unique and compelling invitation to the individual to experience himself, to find and express emotion, to be together with others in a way that is non-threatening, and at the same time intimate and supportive.

DANCE IN THE CLASSROOM: A RATIONALE

Children love to move, and need to move. What can the "facilitating adult" add to this natural mode? In infancy, through the mediation of caring adults, the baby creates a world for himself and an awareness of self through the utilization of the senses and movement. The child's need for these caring adults and the structure they provide remains as the child continues to grow and continues to make meaning out of his activity, his sensations and his needs for the restrictions from the world of "others." Within a supportive structure, this important mode of being, spontaneous movement, can be experienced as meaningful and as valuable--and his body can be included in his growing self, in his transmutation of impulse into art and reason.

What is "dance," which is an art form, an expression of humanness, a communication medium, and a form of "movement"? Any movement <u>can</u> be dance, the awkward and tentative and angry movements as well as the flowing, joyful, graceful ones. What makes the difference? I believe it is the infusion of personal meaning, the <u>self</u>-conscious awareness of moving. "Here I am, and I have something to say"--and as in all art forms, it's something so true, and so strong, that it's best said in images--visual image, language image, sound image, and movement image. That dance <u>is</u> a kind of stepchild of the arts in our culture is, I think, a result of Western Civilization's split of mind and body, a semantic distinction that distorts our thinking about the self-in-action. But even though relegated to a less important role, our bodies refuse to be ignored and carry on their own "sotto voce" conversation--popularized

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and over-simplified recently as "body language." We are the poorer for this denial of our whole selves. Most of us are deprived of a vital area of communication, a way of expressing strong feelings, one of the ways of making meaning out of our lives. When a pre-school or school-age child can see that adults value this natural part of himself, and see it as not antithetical to, but supportive of his growth in social and intellectual behaviors, his whole being will benefit.

DANCE IN THE CLASSROOM: A WAY OF WORKING

A three-fold emphasis--on body experience, emotional experience, and sharing with others--is reflected in movement work with nursery and elementary school children. Sessions begin with "body finding" and movement discoveries, drawing the child's attention to the different parts of his or her body, to joints and how they work, to muscles and how they stretch, to the weight of head or hips and how they pull toward the floor if you "give in" to gravity, to the strength of the body that can be up off the floor and into the air almost before you can say "jump." All these activities are structured by the leader in as natural and unobtrusive a way as possible.

When I work with young children, I try to find cues from them that will suggest to me a structure which will have meaning for them on that particular day. For instance, someone in the pre-school group has a "hurt." We might gently "bandage" our arms, our legs, our heads; we might limp, or crawl, or be birds with broken wings. Meanwhile, I listen hard to what they have to say about injuries and sickness. This kind of beginning might lead to a group "doctor/patient" theme. In one variation of "doctor/patient" the group divided, each choosing to be doctor or patient. The "patients" stood in a circle and volunteered aches and pains ("Ooh, my stomach nurts!" "Ouch, my ankle's twisted!") and we all joined in with appropriate clutchings and grimacings. After a bit, someone would begin to call out "Doctor! Help me, Doctor!" and the "doctors," who had been waiting and watching outside the circle, would rush in, "bandaging," giving "pills" and "ginger ale," soothing fevered brows. Soon the whole group would be on their feet, dancing joyously to a sing-song "I'm all better, I'm all better!" Then we would divide again, doctors becoming patients (though, of course, no child would be pushed to assume a role he couldn't handle), and the game would begin again. The children had created this game, I had helped them structure it, now it was ritualized, and played again and again.

Another example: Coming into a three-year-old group on a rainy day, the leader might use a "rain-on-the-skin" image for focusing on the body--rain on my back, on my head, on my nose, on my knees. . . . As the teacher/therapist encourages the children to move through the "rain" (I like to begin sitting on a rug, or a particular corner of the room, later we move out into the space), someone might begin jumping in puddles (How many ways can you jump?), someone might call out "I'm melting!" and slide down onto the floor in a limp heap. Since melting and growing is usually a favorite theme for three-year-olds, we might elaborate on that theme, perhaps devising a spontaneous story of clouds becoming rain, or becoming puddles, or becoming clouds again, or clouds with various shapes, or rain hard and soft, or puddles flat and formless--or whatever.

Since older children do not associate so freely, they might need more help and stimulation to share their images. With them, body-finding was more structured through "freeze" games, using body parts as well as the whole self, through Simon Sez, or Follow-the-Leader, or through concepts like shapes, weight, space and time. Once someone had brought a lobster shell to school, and we experienced our bones and joints, our shape and ways of moving, by extrapolation from this very different creature.

Perhaps it is hard to see, in these examples, the framework for movement sessions that I expounded earlier. While distinctions blur and overlap, the initial focus is on the body, at rest and then in motion (e-motion). The structure of the session is loose enough to enable individual meaning to be expressed through individual movement. Eventually a group theme is evoked and acted out together in a movement game or story. The burden of sensing the spirit of the group is on the leader, who must see and hear and feel cues, and provide a framework which will allow the expression of the group's feelings.

THE CLASSROOM TEACHER'S ROLE

As an "outsider" coming in to lead movement activities, I relied a great deal on the children's teacher for information about group or individual concerns of the moment. Since the teacher is in the very best position to know these concerns, he or she often makes a most effective leader of movement experience sessions, provided he/she feels comfortable with his own body, and is able to "play." If these sessions are led by a specialist, the teacher's active participation encourages the children and often brings teacher and child together in a warmer, more relaxed way. In addition, teachers sensitized to really "see" movement can gain new understanding of a child's interests, abilities, and difficulties. In movement: play, wishes, fears, needs and satisfactions are manifested, and at the same time can be "played out," giving the child another avenue to the resolution of developmental "growing pains."

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THEME REPORT

Janet Klineman
Susan Aach

EXPRESSIVE ARTS FOR VISUALLY IMPAIRED AND VISUALLY IMPAIRED MULTIPLY HANDICAPPED CHILDREN

With the increased recognition of the value of expressive arts and of learning through creative and problem solving activities in general education, the importance of studying the creative needs of children who require special education has become obvious. Often teachers and parents are so overwhelmed by a child's handicap and his need to gain maximum independence that authoritarian methods of teaching appear to be the only possibilities. However, an exploratory art program for visually impaired multiply handicapped children (VIMH) at Western Pennsylvania School for Blind Children in 1970 opened our eyes to the children's creative potential and their unexpected capacity for growth.[1]

ESEA Title I P.L. 89-313 funds have made it possible to further explore the use of expressive modes of learning in preschool and primary programs over the past four years. We have found that our curriculum requires large components of affective as well as academic education. Visually handicapped and VIMH children have more than the normal amount of stress situations and fewer means of dealing with them. Their sensory deprivation and developmental delays complicate their ways of dealing with problems. Thus, varied learning opportunities are required not only to meet the children's specific learning needs, but also their emotional needs.

To provide expressive modes of learning for children whose individual differences are so great and who have complex learning and behavior problems, we have successfully adapted from principles of the open classroom, The Human Development Program,[2] and have tried to provide the physical and psychological conditions for creative growth.[3]

The children are beginning to explore in various learning centers and their questions reveal a greater curiosity. However, frequently they need the guiding hand and/or verbal encouragement of the adult. In magic circles, they are expressing their feelings with less fear of value judgements placed on their remarks. They are responding to special times for making noises, releasing stored up physical energy, and for experimenting with sand, water, paint, etc., without the fear of disapproval.

There are fewer discipline and management problems in classrooms and dormitories when the children understand that they have times for free expression during the long residential day. For example, daily twenty-five minute

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"private times" with Dr. Klineman helped a multiply handicapped seven-year-old declare her growing autonomy and also helped her accept limitations and share adult time.

Susan Aach, a professional trained and experienced in expressive arts and psychology, is presently conducting a study of expressive arts as part of the 1974-1975 Title I project at Western Pennsylvania School for Blind Children. Based on the children's needs for opportunities to express, clarify and cope with their feelings, she has organized individual and group activities for developing self-expression and creativity in the areas of art, drama and movement. The following examples illustrate how the children are learning to use the different modes of expression:

One day during an art session children were making masks. A totally blind boy discovered that he could make a nose that "felt right." Two questions he often asked were, "How do I do things that look right?" or "How do you, Miss Aach, tell if things look right?" Once he figured the answers out for himself it showed evidence of his growing independence and confidence in his sense of touch.

Creative dramatics provide opportunities for children to work through complicated problems. A ten-year-old girl with a slight residual vision problem role played some scary hospital experiences she had had. "Let's play a game," she said. "Ill be an ambulance driver and you be my brother." "Make an ambulance noise." Through imaginative play Pam was able to express the helpless feeling of being a patient--of not being able to receive orienting cues about the mission of a person in a white uniform. She was also able to move into an authoritarian role and pretend to be the powerful doctor who gave shots to her.

By participating in movement sessions, visually handicapped children become familiarized with the variety of positions and spaces in which they can move. Such experiences imbue the children with a sense of spatial freedom. Kinesthetic freedom is difficult for them to acquire since they have limited opportunities to observe the movement of others. A totally blind girl with mild cerebral palsy gradually overcame her fear of falling through involvement in a movement game. The children took turns pairing up with the teacher and falling together. The girl was able to risk the fall with the physical support of an adult. Each time they landed on the mat the teacher asked the child, "Is your mouth still here? Are your legs still here?" The girl began to deactivate her falling fear with the help of a supportive adult and peers.

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Karlie Roth

CREATIVE DRAMATICS AND THE VISUALLY HANDICAPPED CHILD

Dramatic play has been with us since the first child. All children play to learn and they learn most effectively in their early years by teaching themselves. They teach themselves primarily through an activity called dramatic play. Dramatic play is the application of imitation to make-believe. The child imitates mother's dishwashing and then adds the dimension of make-believe by pretending she is a mother washing dishes after dinner.[1] All children play this way, probably during pre-school days, 50 per cent of the time. The three-year-old pretends house, the four-year-old boy makes and plays with intricate block structures, the six-year-old girls play bride and Barbie doll. All child development theorists agree that it is in this work-play that children learn about themselves and the world around them. By transcending time, place and space through make-believe, the child is growing while simultaneously concretizing his persona.

Creative Dramatics is an elaboration of dramatic play. Its goal is the experiential development of the whole child. By developing the child's sensory awareness, physical facility, verbal ability, imaginative life, and social interaction through experiences that involve the whole child, the child grows individually, socially and humanely.

Unlike dramatic play, Creative Dramatics requires a teacher-guide who selects the games and activities that will catalyze the child's resources. Since no activity is possible without concentration, it is customary for the teacher-guide to start with games that develop concentration and move on to experiences that expand sensory awareness, body movement, imagination, believability, rapport, improvisation, characterization and story dramatization. Indirectly and yet profoundly, the child is engaging in symbolic thought, abstraction, analyzing, widening of concepts and creating new combinations in cognition. Through interaction with his physical and psychic self, the child learns appreciation, confidence and trust. Through interaction with the other children, the child learns positive give and take, self-control, discipline, exposure to different points of view and successful interaction.

Creative Dramatics extends the make-believe, play-work phenomenon of dramatic play to a structured, joyful artistic activity through which the child simultaneously develops and becomes self-expressive.

It is only in recent years that educators have become aware of the incredible potential power of the arts in education. Although Secretary Pittenger said in May 1973, "The place of the arts in schools is central, not peripheral,"

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it may be many years, if at all, that we see any integrated arts program permeate the school curriculum. If educators have not recognized the need for an integrated arts education for the average child, then they certainly will not for the exceptional child. The visually handicapped is inevitably given music lessons, but not art. Drama experiences are limited to radio drama that only requires the participants to speak and duplicate sound effects, but not to interact with each other or the environment. The art mode is compromised to accommodate the "handicap" instead of allowing the basic premises of the art help resolve the problems that the handicap presents. Movement and rapport are two essential ingredients to drama and yet they are the two areas in which the visually handicapped are deficient. By using drama techniques and particularly Creative Dramatic techniques, these deficiencies become assets.

A visual notebook documents and communicates this process. In three months of weekly one-and-half-hour sessions with congenitally blind teen-age girls, it was learned that they could experience their whole selves and communicate through the dramatic medium. A thirty-two-minute video-taped condensation of these sessions, entitled I'll Be Seeing You: Creative Dramatics for Blind Children, can be viewed at the Communication Center, Hillman Library, University of Pittsburgh. It is also available for renting or purchasing.

Learning is facilitated by imitation. Imitation is achieved by copying what is predominantly perceived visually. The congenitally blind child cannot learn to imitate what he cannot see. Therefore, he does not learn the interpersonal, non-verbal communication of the sighted world empirically. In addition to lacking sighted communication skills, the visually handicapped inevitably develops visually unpleasant mannerisms. While everyone has mannerisms peculiar to his own psychology and physiology, congenitally blind children display mannerisms that immediately identify them as blind. These mannerisms give pleasure to the blind or visually handicapped child, so are not easily surrendered. Their educators realize that these mannerisms instantly label them as different and may even repulse the sighted who find it psychologically difficult to break through that visual barrier. If the sighted person gathers courage to break through, he immediately discovers another frustration. It is difficult to "read" the visually handicapped person. If 80 per cent of sighted interpersonal communication is non-verbal, then the frustration of not being able to establish a common non-verbal syntax can be easily understood.

It is not only in small facial and body movements that the visually handicapped child is set apart, but in gross movements also. Theorists believe that Helen Keller moved gracefully (with sighted affect) as an adult because she was walking before she became blind. Imitation and psycho-motor crib play probably helped her to understand her body in realtionship to itself and to the space environment around her. Denied these experiences, visually handicapped children do not sit, stand or walk gracefully. Another division between the sighted and non-sighted world.

Creative movement experiences from early childhood would help the visually handicapped child experience his body in order to learn control, while at the

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same time experiencing a kinesthetic appreciation of the world. A child melting as a block of ice requires physical control, a cognitive frame of reference, and kinesthetic empathy. In dramatizing stories, children learn to improvise movement as freely as they do dialogue. The simple technique of imagining the playing area as a clock with set pieces placed at the hours, is the first step in encouraging movement and rapport with a stage environment. A large identifiable utilitarian, functional area to be deliberately and consciously used, is a new concept to many visually handicapped children. Learning to integrate it in dramatic activity helps the child acknowledge and conquer another world.

Creative Dramatics maximizes rapport with other players as well as with the playing environment. To create believable drama, children must attend to each other as they work to create their roles from the give and take that transpires during spontaneous improvisation. Such heightened concentrated "attending" brings sharpened receptivity, turning the child on to a new dimension of himself and his co-player. When the teacher-guide joins the activity, the child has an opportunity to share this experience with an adult. The first time perhaps that the child has known an adult as an equal.

For some children, loneliness and isolation is first dispelled through dramatic activity. A classic example occurs in Virginia Axline's Dibs In Search Of Self. Dibs is the story of a deeply disturbed child on a difficult journey to self-actualization. His first emergence from his self-imposed isolation comes when he dances and sings his interpretation of the wind. The experience was so complete for his fellow six-year-olds that for the first time his teacher felt that Dibs was one of the group.[2]

Although the primary goal of Creative Dramatics is not therapeutic, it has been recognized that the art process contains its own therapy. In the process of creation, one re-creates one's self.

One of our visually handicapped girl's inappropriate affect was apparent in both Creative Dramatics and real life. Her conversations, as well as improvisations, revolved around herself and were difficult to follow. Without narrative plot action or sustained give and take, neither conversation nor improvisation could continue satisfactorily. Sally liked playing dramatic games and was eager to find a way for herself to be more complete. To continue doing what she likes to do, she surrendered some of her egocentricity and found new rewards in camaraderie.

Through make-believe, children learn behavior that can be beneficially adapted to real life.

My emphasis has been on increasing non-verbal skills through Creative Dramatics for the visually handicapped child. Verbal skills are the most practiced since their communication is all verbal. This does not imply that they are more articulate than their sighted counterpart. They have the same hesitancies, interrupted thought flow, groping for words and meaning, and particularly shyness, that we all experience. Creative Dramatic experiences would increase their non-verbal as well as verbal skills. Sara Smilansky, after intensive studies of sociodramatic play, writes, "It seems likely that improvement in sociodramatic play results in improvement of verbalization during play. It seems that this is

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reflected not so much in quantity of speech as in the quality of it, in terms of more play-related conversation, utilization of broader range of vocabulary, and longer sentences."[3]

Further effort should be made to explore through Creative Dramatics the way and means of helping the visually handicapped child to become effective in his interpersonal communication while joyfully expanding his individual creative soul.

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RESEARCH REPORT

Lynn A. Harris
Martha A. Mattingly, Ph.D.

THE USE OF ART WITH YOUNG CHILDREN

The notion that there is an intimate and very important relationship between art and psychology is centuries old. While psychology embraces a broad area of study, the focus here will be the preschool child and his relationship to art. For as long as this relationship has been noted, little research has been done to explore and define the role of art in the development of the preschool child or the therapeutic use of art with the young child.

Throughout the 1960s some preschool programs were designed to focus on the emotional and social development of young children. Art was usually included as one of the means to facilitate this social-emotional development. Project Early Push (1969), a preschool program in Buffalo, New York, designed its art program to foster self-expression and contribute to the development of self-concept. The art program was not clearly detailed in the project report. A total program evaluation indicated program success on the basis of substantial increases in the children's I.Q. scores. A careful reading of this program description indicates an initial focus on social-emotional development while outcome was measured in terms of cognitive development.

Mooney and Smilansky (1973) recently reported their study of the use of drawing to promote cognitive development in disadvantaged preschool children in Israel and the United States. Realization of the need for effective methods of teaching disadvantaged children was recognized in Israel in the 1950s and came to focus a decade later in the United States. Mooney and Smilansky saw traditional preschool education as serving affective rather than cognitive needs. They developed the notion that preschool children are functionally "reading, writing, and communicating their ideas through pictures." (p. 2) With this in mind they designed a cross-cultural study to compare the influence of art media in the cognitive development of disadvantaged preschool children.

In Tel Aviv, Israel, and Columbus; Ohio, similar studies employing five methods of presenting preschool children with art material were carried out. Approximately 50 children, 25 pre-kindergarten age and 25 kindergarten age, were exposed to one of the five teaching methods in both Columbus and Tel Aviv. (A total of 434 children participated in the study). The classroom teachers were major participants in the study; they served as facilitators and had a part in administering the evaluation. The five teaching methods were as follows: The control group was informed that drawing materials were available in the classroom; experimental condition 1 consisted of a discussion along with the presentation of drawing materials; experimental condition 2 was a presentation of

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material, discussion, and the opportunity to observe models; experimental condition 3 permitted in addition the touching and handling of models; the final condition, 4, added direct training in basic artistic skills. The study lasted ten weeks with three one-hour sessions each week. A battery of ten tests was developed to assess verbal and artistic development as well as cognitive performance.

The experimental methods produced significant gains in all the assessed areas while the control method did not. Results indicated that observation and technical training were most effective. Results were also generally similar for both national groups. It was concluded that drawing is an effective medium for developing cognitive abilities, when carefully designed methods are employed. Disadvantaged children from the two countries were seen as having similar needs and potentialities. This study also pointed out the need for the classroom teacher to be a full participant in the research and to understand their part in the study. It was also seen as essential that the teachers be able to gain intrinsic rewards for their efforts.

Schwartz and Douglas (1967) studied art as a means of increasing the awareness of five-year-old culturally deprived children through experiences with ceramics. They described culturally deprived children as deficient in visual perception, discrimination, processes of thinking and in language skills. An experienced teacher knowledgeable in early childhood education and art education presented the children with selected basic art ideas through guided participation in observing and discussing ceramic art works and modeling in clay.

For eight weeks, fifty-four five-year-olds participated in two one-hour sessions a week. Ceramic art works and other visual stimuli were presented to the children in the experimental group and four questions were posed: 1. What is it? 2. Who did it? 3. How did he do it? 4. Could he do it with an alternative medium? The control group shared the same first and last sessions, but were only presented with the medium-clay during the intervening sessions. Three judges rated the children on verbalization and use of the medium. Data revealed that awareness to art ideas were increased when a teacher, knowledgeable in early childhood education and art, helped the children observe, discuss, and execute ceramics in terms of the concepts presented. The experimental group was more verbal and creative while the control group rated zero in verbalization and was more stereotyped in their creativity. Increase in verbalization and expanded creativity were seen as evidence of cognitive gains. The control group was described as using the clay as an activity in itself and not as a means of discussion. Teachers were identified as important persons to help the child define questions, identify, and use the visual art materials.

As noted previously, little research has been reported which defines and differentiates the role of art in young children's development. This particular review illustrates several viewpoints on how art can be used in preschool programs. It also points up the absence of the systematic basic research necessary for us to understand and make effective use of art in our profession.

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THE INFANT

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WHAT'S NEW WITH THE NEWBORN?

Despite the near attainment of Zero Population Growth there are still close to four hundred babies born in the United States each hour. Possibly because of ZPG there is increasing concern that these new citizens get off to as good a beginning as possible. This concern seems to be coming from several different sources and is reflected in a variety of new approaches to community programming for young families. What are some of the converging channels of interest, and what types of programs are emerging?

One channel flows out of research in developmental psychology. Up until relatively recently the prevailing view of the neonate was that it was a far-sighted, undifferentiated, bundle of uncoordinated reflexes, living in a world of "buzzing blooming confusion," to quote William James, and not sufficiently developed cortically to sort any of this out. However, developmental research in the past decade has increasingly demonstrated that the newborn is capable of a wide range of responses and can already "process" information. Within hours of birth, visual following and tracking can be measured and a strong preference for staring at linear or zigzag patterns rather than solid colored objects may be observed. The pattern of a face becomes preferred as early as three to four weeks. Sound localization has been observed as early as ten minutes after birth. The "information explosion" about the infant has pushed back the frontiers of "early" experience, as research findings are being translated into action. There has been widespread acceptance of Piaget's conceptualization that the infant is experiencing, interacting with the environment, and modifying, changing and learning, from the moment of birth.

Another related channel derives from the educational research and evaluation of such programs as Project Head Start. The inequalities in school readiness, as a function of poverty and environmental limitations, apparently are not readily correctable in the later pre-school years. It has become increasingly evident that <u>early</u> experience means the all-important first year of life when the foundations of later learning are laid down.

Seven out of every one hundred infants have handicapping conditions that are recognizable in the first year of life. The passage, in many states of the so-called "Right to Education" laws guaranteeing educational opportunity to all children regardless of physical, sensory, emotional or social handicapped conditions, has led to a long hard look at the possibility of early diagnosis of such conditions. The emphasis is on the need for early recognition and the earliest possible intervention for these handicapping conditions, so that each child may achieve his or her fullest learning potential as guaranteed by the law. In some states the right to education is guaranteed only at the usual age of school entry, but there is a strong and increasing trend toward mandating services in the pre-school years, and in some states educational services to all infants are mandated to birth. "Educational" in this context is rather broadly defined and usually involves assessment of developmental levels and helping parents to work with infants to encourage optimal developmental functioning.

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Another dimension of the problem derives from changes in patterns of family organization. The traditional supports of the extended family are not as readily available in our increasingly complex and highly mobile social structure to young couples entering parenthood. First-time parents particularly find themselves needing help in understanding the many rapid changes which are part of normal growth and development. Assisting them to cope with their anxieties through family intervention or infancy counseling, can help to promote healthy emotional development in the infant and provide satisfying foundations for parent-child interaction.

From these converging channels of thought, there has been a rapid growth of programs of infant intervention and infant stimulation. Some of these programs have developed as a result of parents themselves organizing together to meet needs that the community had not as yet recognized; and the influence of parent groups in this area has been enormous. The pattern of such infant intervention programming varies from community to community, but a few generalizations may be made. For the most part, these programs are multi-disciplinary and staffed by people who have a fine background in child development and family relations. Their training may be in one of a number of relevant disciplines, such as education, psychology, social work, pediatrics, for example. The emphasis is on working with the whole family--training mothers, fathers, and other important family members to recognize the infant's needs and capacities and teaching parents to carry out appropriate techniques of stimulation and remediation. The focus is on the home, and often the intervention and even the developmental assessment is carried out within the home. A new kind of professional, a child development specialist, or an infancy counselor, is appearing on the scene. Parents, too, can help each other, and as services expand, training is being extended to experienced parents to enable them to work in infancy intervention programs of various types.

The ultimate goal of all infant intervention programs, whether they deal with delivery of educational and rehabilitation services to the handicapped infant, or with delivery of mental health services to young people seeking reassurance and support in working out their sense of identification as parents, is prevention. Preventive programs are difficult to evaluate since the consequences of such programs do not show up immediately on the statistics charts. Preventive programs are sometimes difficult to implement because there are problems involved in reaching out to those people who really need the services you are offering. The trend is toward bringing infant intervention programs out of the hospital, school, clinic, etc., into the neighborhood, the churches, the homes, where the potential consumers are. Also, the potential consumers are beginning to request these services. There is an increasing awareness on the part of many young people in our society of the importance of the parental role. We only approach Zero Population Growth through increasing acceptance of parenthood by choice. Choice implies acceptance of responsibility on the part of both parents for doing the best job they can.

Lawrence A. Bloom

LANGUAGE ACQUISITION IN THE EARLY MONTHS OF LIFE

The development of language skills begins at birth, and is a well established process by eighteen months of age. Linguistic growth of a child evolves as a result of the interaction of many aspects of heredity with many aspects of environment. By far the most important aspect of the infant's environment which bears influence upon his language acquisition is his mother. Language develops along three highly related developmental pathways; neurophysiologic, cognitive, and affective.[3] This paper will deal primarily with the affective aspects of development.

One of the most impressive facts about normal language development in humans is its universality and consistency.[2,5] de Hirsch points out that "while children vary in the rate with which they incorporate the linguistic code--at least within certain limits--early speech milestones appear at roughly the same time. The large majority of children babble, use stress and intonation, utter two-to-three word combinations and acquire the basic rules of their language at about the same age. Without formal training, children incorporate a set of assumptions and rules regarding their langugage which allows them to understand and generate new forms."[2] This seems to be generally true from language to language, country to country, culture to culture, and even in those cultures in which it is not customary to speak a great deal to infants. This has led many to the assumption that children are born with "certain propensities which enable them to extract from their linguistic environment the relevant information needed in order to organize a language system."[2]

The mother-infant relationship, particularly within the first several months of life, constitutes the major environmental impetus toward the fulfillment of linguistic potential. The importance in the first months of life of the mother's voice has been stressed by many.[2] It has been observed that the mother "caresses the child with her voice," and that the dialogue between the mother and her baby becomes a process of "mutual feedback." However, the quantity of the mother's speech cannot by itself account for the immensely complex process which is language acquisition. The assumption that children learn language primarily through imitation has been strongly refuted by psycholinguists.[5]

Mahler gives us a more complete concept of mother-child interaction, which would seem to be a far better and more thorough explanation of the early communication process. She states:

> Among the many elements of the mother-child relationship during early infancy, we were especially impressed with the mutual selection of cues. We observed that infants

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> present a large variety of cues--to indicate needs, tension, and pleasure. In a complex manner, the mother responds selectively to only certain of these cues. The infant gradually alters his behavior in relation to this selective response; he does so in a characteristic way--the resultant of his own innate endowment and the mother-child relationship.[4]

It would seem that Mahler is describing the deepest and most basic type of communication which would certainly tap the "linguistic potential."

This basic type of mother-child communication is discussed in a similar way by Eveloff, who states:

> The beginning of a true bi-directional communication system, in my opinion, has its inception . . . with the appearance of the human social smile. . . . The smile is the first interaction between mother and child that has no counterpart in other species . . . it fosters the mother's illusory belief that "my baby really knows me," thereby providing increased emotional impetus to keep the dyadic process fueled. . . . The social smile and all that it entails, in my view, provide the first discernible step of mutality in the development of language. . . . If no sensory or motor difficulties have arisen in the control of the organs used in speech (organs of eating and breathing), then the child will enter the next stage of random articulation or babbling at about three months.[3]

Research findings have lent strong support to the assumption that the mother's speech to the infant has great impact upon his development. Although a recent study by Condon and Sander deals primarily with the spoken language, it is not difficult to imagine that this same process applies to all aspects of "mutual cueing." Condon and Sander studied the synchronization of minute infant movement in correspondence with adult speech. They state:

> This study reveals a complex interaction system in which the organization of the neonate's motor behavior is entrained by and synchronized with the organized speech behavior of adults in his environment. If the infant, from the beginning, moves in precise shared rhythm with the organization of the speech structure of his culture, then he participates developmentally through complex subsociobiological entrainment process in million of repetition of linguistic forms long before he later uses them in speaking and communicating. By the time he begins to speak, he may have already layed down within himself the form and structure of the language system of his culture.[1]

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It would seem that these varied and complex mutual-communication systems are a part of the strong early bonding between mother and child, which in turn later enables the child to safely separate and individuate.[4] The process of separation-individuation is inextricably entwined with the process of the development of language: "the means by which one human being intentionally contacts another in a mutually understood, representational manner in order to convey an ideational or affective message."[3]

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THEME REPORT

Pauline Medice

THAT IMPORTANT FIRST YEAR

Based on Spitz, René A. The First Year of Life: A Psychoanalytic Study of Normal and Deviant Development of Object Relations. New York: International Universities Press, Inc., 1965.

For those not schooled in psychoanalytic theory, Dr. Spitz's works present a real challenge. Even though the Preface written by Anna Freud states: "This detailed and painstaking description of the emotional interchange between mothers and their infants (my underlining) aims at a wider circle of readers than is usual with publications by psychoanalysts. The author's language, backed by striking illustrations, is direct and simple enough to be understood by mothers and workers in the field of infant care, even in the absence of previous psychological instruction." This reader, mother and early childhood education professional, found the material quite intense. However, considering the psychological limits, this author will report some of the developmental theories outlined by Spitz. He has done a multitude of work in the area and although the only complete work read by this author was The First Year of Life, he refers throughout this book to his other works over the years. For a complete bibliographical listing of these works, please refer to the bibliography in the back of his book.

To trace the happenings in the first year of life, Spitz uses direct observations and methods of experimental psychology. He began his systematic investigations in 1935. His results of research, observations, and recordings are based on hundreds of infants. For details of methodology and subjects, see chapter two. In this book Spitz introduces the reader to a variety of methods and findings exploring the nonverbal stage of life from a psychoanalytic viewpoint. His investigations of infants is based on the propositions and concepts which Sigmund Freud set forth in the Three Contributions to the Theory of Sex. Spitz categorized the nonverbal developmental era into three major stages; 1. the objectless stage, during which the first organizer emerges; 2. the establishment of the libidinal object or the second organizer; and 3. the beginnings of human communication or the third organizer of the psyche.

During the helpless first year of life, the infant lacks survival techniques. What the infant lacks, the mother provides. The outcome is what Spitz refers to as a "dyad." This seems obvious in the physical realm, but this is also true in the psychological sectors of the infant's personality. A purely biological bond, in utero, is transformed into a stage of psychological "symbiosis." This refers to the living together in close union of two dissimilar organisms or, namely, the infant with the mother.

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The beginnings of this transformation, from utero to symbiosis, form the objectless stage. In the world of the neonate, zero to one month, there is neither object nor an object relation. The perceptual apparatus of the newborn is shielded from the outside world by an extremely high stimulus barrier. Spitz speaks of this stage as the undifferentiated phase because the newborn's perception is not organized into units.

In comparing born-blind adults whose vision was restored to newborns, some essential pieces of information were provided concerning infants and perception. 1. Perception appears to begin as a totality, and various perceptive units have to be segregated from each other in the course of development. 2. Perception in the sense in which adults perceive is not present from the beginning; it must be acquired and learned.

While observing neonates during nursing, it was found that their eyes were consistently on the mother's face. The baby has contact perception, for the breast or bottle is the first oral-contact percept. The first "object," as has been accepted by psychoanalytic propositions, is not the breast. Rather, maturation and development combine to bring a shift from contact perception to distance perception. The infant staring at the mother's face serves to develop distance perception. This theory can be seen beginning with the fourth week of life. There is only one percept which the infant follows with his eyes at a distance. This is the grownup's face.

The baby continues in this minimal stimulus environment for approximately three months. At age three months, the baby responds to the adult's face by smiling if certain conditions are fulfilled. The face must be presented straight on so that the infant can see both eyes and the face must move. At this age, nothing else provokes this response. This smile is the first active, directed, and intentional behavior. It is the first indicator of the infant's transition from complete passivity to the inception of active behavior. Further, children before the age of two months will not smile reliably at anybody, or anything. The same children after reaching the age of six months, reserved their smiling response for their mothers, or their love object and would not smile at strangers. The significance of the smiling response is the emergence of the first organizer which shows some memory traces, some acceptance of stimuli, some beginnings of ego and some directed activity in the infant.

Changing from a non-responding entity to a smiling-response infant is no simple matter. The first year of life is the most plastic period in human development. Never again in later life will so much be learned in so short a time. The smiling response marks the end of the first stage of several which represent a major transformation from the preceding one. After the stage of complete helplessness and passivity, the infant passes through a stage during which he explores, probes, and expands his territory. During a transitional stage, the infant's experiences have more far-reaching consequences than at other periods when his psychic organization is more stable. Certain conditions need fulfillment in order for the infant to pass successfully through the complex and difficult processes of this first major stage of transition. Prominent among these conditions is the atmosphere of security, which is provided by stable and consistent object relations. A continuous interchange must be available to the infant, in the form of affect directed to the libidinal object, leading to interaction between infant and object.

Through this interchange, the young infant receives sensations arising from bodily organs through which he perceives his own body. How can an infant receive coenesthetic signals? The coenesthetic system responds to nonverbal, nondirected, expressive signals. Signals and signs that reach the infant in the first months of life are in the following categories: equilibrium, tension, posture, temperature, vibrations, skin and body contact, rhythm, tempo, duration, pitch, tone, resonance, clang and perhaps others an adult cannot verbalize. This does not mean that an infant should be overpermissively attended to. To deprive the infant of the affect of displeasure during the first year of life is as harmful as to deprive him of the affect of pleasure. The importance of frustration for developmental progress cannot be overestimated--nature itself imposes it. Spitz believes birth is the first frustration encountered and not a trauma as believed by some authorities.

Up until the eighth month the infant is in the objectless stage. After this point, no longer will the baby respond with a smile to friend or stranger who approaches his crib. Spitz calls this the eighth-month anxiety and considers it the earliest manifestation of anxiety proper. Like the smiling response at the age of three months, the eighth-month anxiety marks a distinct stage in the development of the psychic organization. This anxiety means the child remembers his mother's face and that he has now established a true object relation. The mother has become his libidinal object, his love object. This indicates the emergence of the second organizer of the psyche. Therefore, one of the critical periods is situated around the eighth month of life. This marks a point where the child's personality and his behavior will undergo a radical change.

As the child was emerging toward the formation of the second organizer, reciprocal communication, directed, active, and intentional developed between the child and his mother. These communications are gradually organized into a kind of system of semantic gestures, which later will be transformed into verbal ones. The child now also develops a progressive understanding of prohibitions and the first traces of identification phenomena emerges.

Soon thereafter negative head shaking by the child appears. The mastery of the "No" both the gesture and then the word, is a achievement with far-reaching consequences for the mental and emotional development of the child. It presupposes that he has acquired the first capacity of judgment and negation. This is the first abstract concept in the sense of adult mentation. Since this is the origin of verbal communication, Spitz considers this the indicator of the formation of the third organizer.

The foregoing is a brief outline of the genetic and developmental aspects of a psychoanalytic psychology of the first year of life. This has been based on the figment of the "normal" child and its "normal" development.

In part three of the book, Spitz expands on deviant relations which result in psychotoxic disturbances of three-month colic, infantile eczema, rocking in infants, fecal play and coprophagic and the hyperthymic child. He also considers anaclitic depression and total emotional deprivation. These case histories and observations, along with his oratory, are fascinating reading.

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This quote from Spitz's conclusion, speaking of broken mother-child relations, serves as a good final statement:

> Disturbed object relations in the first year of life, be they deviant, improper, or insufficient, have consequences which imperil the very foundations of society. Without a template, the victims of disturbed object relations subsequently will themselves lack the capacity to relate. . . . Their capacity for normal human and social relations is deficient; they were never given the opportunity to experience libidinal relations and to achieve the anaclitic love object. . . . Infants without love, they will end as adults full of hate.

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THEME REPORT

Philippa H. Campbell

THE INFANT AND SENSORIMOTOR DEVELOPMENT

The importance of very early reactions of the infant to his environment and the significance of these early reactions to the infant's later learning and development has been explored in considerable detail. Initially thought to be a passive organism without self-initiated responses, research conducted by Brazelton, Kagan, Lewis, and White and their associates, has demonstrated that the very young infant is far more active, self-directed, and constructive in interacting with his environment than was previously thought. Reactions of the young infant to his environment were recognized and described by Piaget as part of the development of intelligence. Labeled as the sensorimotor stage because these reactions to the environment occurred prior to the development of language (symbolic behaviors) and as such were behaviors without thought processing, Piaget related the significance of this stage to the development of perceptual schemes which later formed the basis for cognitive thought.

More recent research in the area of sensorimotor learning has attempted not only to establish the relationships between sensorimotor behaviors and later "intelligence," but has also attempted to identify, more accurately and precisely, the schemes which the very young infant uses in interacting with his environment and how these schemes develop. To this extent, considerable emphasis has been placed on studying infants longitudinally under differing environmental conditions, observing the manners in which they react to specifically controlled stimuli under specifically controlled conditions. Burton White and his associates at Harvard have studied the effects of differing enriched environments on the newborn's acquisition of early visual and visual-perceptual sensorimotor behaviors. His research has consistently demonstrated that infants who are handled frequently acquire coordinated visual attention and reaching behaviors more rapidly than infants who are handled less frequently. He has hypothesized, as has Piaget, that the significance of handling suggests evidence of the early inter-relationships of the visual-tactile-kinesthetic modalities in the infant's learning. White, in addition, has stressed the concept of the plasticity of the visual-motor system in the young infant when the movements of the infant can be made self-induced rather than externally produced.

While the relationships between early sensorimotor behaviors and later intelligence have not been well established, attempts have been made to develop methods of assessing the infant's skills in reacting to sensory stimuli. Most scales and measures have concentrated on relating the infant's development to developmental norms, items at the earliest levels generally being measures of neurological status. A recently published neonatal behavioral assessment scale by T. Berry Brazelton has made assessment of sensorimotor behaviors possible as

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early as the first day of life. The scale rates the stereotyped behavior schemes which newborns characteristically use in response to certain stimuli (reflex behaviors), but more importantly, it also rates the infant's behavioral responses to non-reflexive eliciting stimuli under maximum conditions. Significant (and different) is the underlying concept of eliciting the infant's best response during the baby's most alert stage. As such, the scale does not rate observations or passive manipulations of the infant, but rather rates the infant's self-induced responses to its environment. At this time, research done using the scale, has demonstrated that ratings from this measure are more accurate in predicting later infant behaviors than other assessment devices used with young infants. Infant responses which are being rated are sensorimotor in nature indicative of the importance of the early development of self-induced motoric responses to the stimuli which the infant receives from his environment.

As our understanding of the nature and significance of sensorimotor development has grown, greater importance has been given to the early experiences which the infant and young child receive as part of their care. Psychologists and early childhood educators, as well as therapists, have become more involved in establishing environmental experiences through which the infant can develop motoric responses to the sensory stimulation provided through environment manipulations. Due to the plasticity of the infant's central nervous system, enriched sensorimotor experiences may provide the child with a stronger basis on which to build later academic skills.

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Michael Painter, M.D.

THE HIGH-RISK INFANT

The care of newborn infants, particularly premature infants, has changed dramatically in recent years. In the past there was a widespread pessimism regarding the outlook of the small premature as to both survival and eventual mental retardation. It was common practice to place a premature infant in an incubator and simply observe the infant for twenty-four hours to see if he or she survived. If the child survived this observation period, then such standard practices as the use of intravenous fluids and careful feeding were instituted.

In the mid-1960s, more intensive techniques were used in the treatment of small prematures. Careful attention to the maintenance of body temperature was practiced. The concepts of delayed feeding was abandoned and early intravenous therapy followed or accompanied by early oral feeding was adopted. Infants at risk for hypoglycemia and/or hypocalcemia were screened and treated prophlactically for these disorders. Physicians caring for these small infants became aware that lower levels of jaundice would result in brain damage than previously suspected, and measures were therefore taken to keep bilirubin at very low levels.

As intensive measures were taken to care for these premature infants, the concern arose that as more preterm infants survived, more developmentally impaired children would result. On the basis of information obtained by investigators such as Drillien and Lubchenco, the concern was a realistic one.

In children with a birth weight of less than 1250 grams, Drillien found less than 50 percent had IQ's of less than 90 and 28 percent had significant functional neurologic impairment. Lubchenco found that 43 percent had an IQ of less than 90 and 32 percent had significant neurologic impairment in a group of infants who weighed less than 1500 grams and survived. Of note is the fact that these were infants who were born and cared for between 1947 and 1960.

Rawlings evaluated infants who had been cared for in an intensive fashion in 1971 and noted that not only had the survival rate of low birth weight infants increased, but the incidence of sequelae appeared to decrease. Only 67 percent of the surviving group of infants who had weighed less than 1500 grams at birth had significant neurologic deficits at follow-up evaluation and only 15 percent had IQ's less than their parents.

It would appear that those factors that had increased mortality in the past had also increased developmental sequelae. Careful monitoring, detection and treatment of such entities as malnutrition, hypothermia, jaundice and hypoglycemia have appeared to decrease the incidence of subsequent sequelae.

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Another apparent factor would appear to be early prevention and treatment of hypoxias. Since the initial evaluation by Rawlings, there have been several subsequent articles attesting to the lower than expected frequency of developmental sequelae in low birth weight populations.

We have just concluded an evaluation of premature infants with hyaline membrane disease who required artificial ventilation and were treated at Magee-Womens Hospital from 1969-1972. Of 33 survivors, only 8 were developmentally abnormal because of neurologic disability, but had normal intellect. Two of the remaining 4 appeared to have borderline retardation in the base 7 psychologic testing, but their performance was not significantly different from their parents or siblings. Only 1 of the 33 children could be said to have had significant developmental delay clearly due to events occurring in the immediate perinatal period.

The results then of neonatal intensive care would certainly appear to justify its existence and are certainly superior to those achieved by routine care in past years. This incidence of developmental abnormality, however, may not be irreducible. The role of early detection, remediation and infant stimulation on long-term developmental lag has yet to be assessed.

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THEME REPORT

Ethel Tittnich

INFANT ENVIRONMENTS

After the first few years of Head Start, some educators wondered whether providing optimal stimulation during the pre-school years was a bit too late. Attention was given to the years under three as being more nodal for environmental stimulation. With ever-increasing programs for younger children, it is important to consider the needs of the young child in the first year of life and the kinds of stimulating environment which would best facilitate growth.

Prime consideration should be given to the major developmental tasks and needs of the infant during this time; regulation of physiological mechanisms, developing fine and gross motor control and perceptual coordination, developing awareness of self--and others apart from self--developing trust and a beginning sense of potency on the environment, developing an increasing awareness of and curiosity about the world around him and his ability to act on it.

In order to facilitate development by appropriate stimulation, it is necessary to understand the needs of the developing infant. Above all, he/she needs to be considered as an individual who already has foundations (biological givers) which will influence his/her future interactions with the environment. It is most important to consider the unique personalities, styles and cueing patterns of the individual infants.

One of the greatest needs of an infant, one which very much influences his emotional development and capacities for future successful interactions, is the need for consistency. By having his needs consistently met; by experiencing only minimal frustration; by having the opportunity to act on the environment; by developing ability to predict results of his action and by affectionate interactions with a few consistent adults, the infant develops an awareness of himself as a worthwhile person capable of exerting some increasing influences over himself and his environment.

Another major area of need consideration is the baby's interaction with the environment. His surroundings should stimulate his senses in a way to arouse curiosity and wonder, but not so much as to overwhelm him and cause anxiety. Since individual infants react differently, it is necessary to consider the tolerance to stimuli of each infant. The stimuli needs to be regulated by the adult auxiliary ego, since it is through a relationship with meaninful adults that the baby can start to make sense of his environment. As the adult--most often the mother, but also father and/or other consistent care-givers--helps the infant to become aware of and respond to his environment, the infant--in turn--will evidence curiosity and action on his surroundings. It is then important that the adult respond to these overtures appropriately by reinforcement, mirroring, imitation or extension of the action.

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Language, of course, plays a major role in the adult's mediation of the environment for the infant, both in regulation and organization, of the external world, and in social interactions. At the time when the baby begins to vocalize, he should be talked to. If the mother holds her face near the baby's, while talking to him, he will try to respond. As he increasingly attempts to "talk," the mother, by imitating his sounds and talking, reinforces and extends the activity for him. The baby will, of course, need to have physical needs satisfied so that he/she is adequately fed, kept safe and secure, and relatively comfortable.

During these care-giving times, the adult-infant interaction is important for stimulating interest in the activity and to extend the learning potential in it.

Feeding

While the nutritional value of feeding time is obvious, such activity as feeding does not preclude learning and development which can occur in the child. The young infant receiving formulae would be held while fed. As more and more solid foods (1½-2 mo.) are introduced, the child could sometimes be placed in a baby chair so that he can see the mother during feeding (the infant should still be held for bottle feeding). Such feeding process would coincide with increased muscle control and perceptual development. As the child evidences readiness for a high chair or feeding chair, he will probably be more active and show a desire to participate in his feeding. At this time, the adult would help the child by giving finger foods, by giving the infant a spoon and by helping him spoon food into his mouth. During feeding, the adult should also talk to the infant.

By twelve months of age, the child's participation in mealtimes should be assumed. He can eat finger foods and even spoon food into his mouth with help and guidance. The adult should still talk and smile with baby and hold him at some time during the feeding. The feeding schedule should be individualized.

Bathing-Diapering

Again, bathing or diapering while having a prime physical purpose can also be growth-promoting for the child. Because of the physical contact required, this would be an opportune time to engage in interaction requiring touching, patting, nuzzling (as tolerated by the infant), as well as talking and laughing (if appropriate), or singing, humming. The adult could play games such as "This little piggy"--touch the toes to the nose--"Peek-a-boo," etc. The adult could also name body parts as she washed the infant. As with feeding, as the child gets older, he will want to participate in these activities. The adult needs to assess the baby's ability and help him to become part of (instead of limiting participation in) this physical care-giver to himself. She could do this by providing toys at first, but later, she could help him feel the soap and even give him an extra wash cloth to enable him to "play at" bathing.

Rest-Sleep

As the baby grows older, he will sleep less and less during the day. It is not necessary to program for every minute of wakefulness, but the times of

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rest should be short periods alternated with more active times. Some of the short rest periods can be spent in the crib, other times the infant could be held quietly by the adult. During periods of wakefulness it is important for the adult to determine those periods during which the infant would be most receptive to activities. During any day infants will engage in adult-initiated and self-initiated play.

Infant Activities

These activities would include the range of play possibilities from playing with words and sound to play with toys.*

Up to about three months of age, "play" would revolve around body functions (i.e., sucking) and social interactions (e.g., playing with sounds and listening). During this time the social smile develops and the baby can track a toy within a limited visual range.

At about three months, the baby becomes more social and wants to interact with people. In the next several months, he will be able to track objects, reach for objects, look for objects, especially human faces, out of sight and let go of objects and intentionally repeat activities to get results. He will turn to sound and try to talk back to persons who talk to him. Activities should be planned with the above capabilities in mind. (Suggested activities can be found in many guides to infant play.)

At six months of age, the infant begins to differentiate himself and others so that kinesthetic activities in which the child can touch himself and others, or experience dual sensation of his own body (biting or sucking his own body part) would be important. Mirroring his activities, as well as using a mirror in which he can find himself, should also be included. Peek-a-boo and hiding games would also be appropriate.

Since the baby's vocalizations are becoming more differentiated, language activities (e.g., labeling) and talking should be continued. Important, too, is that the adult listen to the baby and repeat his vocalizations just as she would his activities in mirroring or imitation. In turn, the baby will imitate the adult.

The baby six to nine months is now more interested in toys and adding a selection of toys which are of different shapes, textures, etc., also aid in the differentiating activity pertinent to this age. Toys should always be introduced by the adult who should name the toy and help the infant explore it.

From nine to twelve months, the baby will be much more active in exploring his environment. He may want to practice climbing or walking and will need

*The play of an infant will progress from play with body to play with mother's body or adult. Through the adult, the baby will gradually begin to show interest in toys and will be able to spend short periods playing alone with toys. Near the end of the first year, the baby will show interest in active exploration of the environment.

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the support of the adult to aid him physically and to make the environment manageable. Accompanying increased physical activity, is more active exploration and manipulation of the environment. Peek-a-boo and hiding games continue to be fun and can be much more expansive since the infant can actively "hunt" (move around the room) or be "hunted."

Since the baby will probably have developed fine motor skill of grasping, games like dropping objects in a container or stacking containers would interest him. Now the baby imitates words so that labeling and talking about him and his world becomes very important. Throughout the whole year, this activity becomes more and more important as an aid in differentiation of self (body parts) from others.

In introducing any activity for an infant, it is important to remember the mediating activity of the adult. It is also necessary to plan for variety, but all new activities need to be introduced with some old familiar ones. Consideration should be given to the infant's need to repeat an activity to master it and even previously mastered activities of a younger age can be included in play time at a later age.

Some of the activities mentioned above can be done by the infant alone. During each day, he should have time and appropriate space and materials so that he can do what he wants (explore) and regulate his own activity with adult supervision.

Outdoors

When weather permits, the infant should spend some time outdoors. By varying in a thoughtful way, the kinds of experiences the child is exposed to, the adult helps him to extend his world and his understanding of it.

The above activities represent only a guide. An environment which is responsive to the child's needs and adults who knowledgeably facilitate growth are primary essentials of any program aimed at stimulating infants to healthy growth and development.

Programs for Infant Care

With more and more programs being developed for infants outside the home, it is important that the above essentials be included. The responsibility for care of infants is often given over to agencies who can provide for optimal environments. The two major kinds of care for infants are group care and family day care. The succeeding reports on "The Ed-Med Infant Toddler Program" and "A Look at McKeesport Family Day Care" describe each kind of program as evidenced in specific existing agencies.

LEARNING DISORDERS AND YOUNG CHILDREN

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IDENTIFYING LEARNING DISABILITIES IN YOUNG CHILDREN

The term "learning disability" or minimal cerebral dysfunction encompasses a very heterogeneous population. It describes a continuum of deficits a child may have in acquiring the basic alphabet of sounds and shapes in the environment because of perceptual or perceptual motor deficits. Some children may have a known history of disease or trauma affecting the central nervous system, while others have familial or constitutional differences.

The preschool teacher, because of her developmental orientation and familiarity with the normal attainment of the 2-5 year old child, will have a sensitive awareness of the "different" or immature child. Behaviorally, many but not all of these children exhibit a cluster of traits such as hyperactivity, distractibility, disinhibition, impulsivity, perseveration, lability of affect and motor dysfunction. Perceptual deficits manifest themselves in the inability to recognize the fine differences between sounds used in speech in the absence of sensory deficits, difficulty in ordering sounds or shapes sequentially, in distinguishing figure ground relationships, inability to recognize temporal or spatial sequences, and relating what is perceived to specific motor functions.

Children whose learning problems are primarily due to mental retardation, emotional disturbance or environmental disadvantage may also have some of the above-mentioned characteristics. The labelling issue is serious and much work has been done to examine the effects of labelling. Anything that challenges an individual's functioning in either the intellectual or the emotional areas arouse great anxiety. Although minimal cerebral dysfunction and brain damage are currently used by many states to label children, special educators are diligently searching their lexicon for classifications that are less pessimistic and reflect the trend toward behavioral rather than medical classifications. Cruickshank had recently recommended the classification of specific learning disability to supersede minimal cerebral dysfunction. Specific learning disability will refer to those children who have substantial deficits in an area of learning because of perceptual or perceptual motor handicaps regardless of etiology or other contributing factors. Headstart programs, day care centers and nursery schools, because of their very flexible curriculum and grouping, are ideal settings for integrating handicapped children while providing treatment and habilitative programming.

The synthesis of a developmental and behavioral approach provide an effective framework for the identification of learning disabled preschool children. A synthesis of the two approaches minimizes the limitation of standardized tests for measuring behavioral characteristics in very young children. A purely developmental approach will not identify children with learning disabilities as much as it will identify children who are deviating from the accrued norms. The Denver Developmental Screening Test appears to be an adequate instrument for a wide range of populations of preschool children. It is easy to administer and requires little specific training other than that the examiner be a good and unbiased observer of child behavior. The second task in identifying preschool learning disabled children is to assess particular observable behaviors that are

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symptomatic of learning disabilities. The causes are not pertinent in the identification task. The behaviors or symptoms are derived from empirical experiential evidence. The eight empirically validated behaviors with learning disabilities become increasing reliable indicators after the age of three.

a. inadequate ability to reproduce simple figures

b. inability to remember the separate sounds and sequence of words

c. inability to visually perceive and remember words and other symbols and their sequence

d. inability to separate form from field

e. inability to maintain direction in speech or space

f. inability to reproduce rhythm patterns

g. inability to coordinate large muscles and small muscles

h. inability to control actions and emotional responses

The teacher will find the Circus Battery (ETS) and the Metropolitan Reading Readiness test helpful in assessing the behavioral symptoms.

Once the teacher has identified the child with a learning disability, she will want to refer him to a multi-disciplinary team for differential diagnosis. Diagnosis has a two-fold purpose, namely, to discover the nature of underlying difficulties and to provide information on how to remediate the disability. For example: If the child's disability is caused by an emotional disturbance, the habilitative process would be designed to remediate this problem, or if the differential diagnosis indicates the primary problem is mental retardation, the recommended habilitative program would be in accordance with the diagnosis. The multi-disciplinary team may consist of pediatrician, a pediatric neurologist, psychologist, speech and language pathologist, learning disability specialist, audiologist and occupational therapist. The differential diagnosis of a learning disability is obtained by a careful study of the child's medical history, psychological evaluation and clinical observation. Psychological evaluation should proceed with an overall evaluation of the child's intellectual performance, language development and behavioral characteristics. A detailed assessment of perceptual processes, such as discrimination, memory, orientation in space, figure ground relationships, closure and intersensory integration in both auditory and visual modalities lay the groundwork for educational programming. A whole child is not an I.Q., a self concept, a disease or a maladaptive behavior. However, we need to know, if we are going to enhance a child's development where problems exist, what interventions will produce maximum gains.

Preschool programs, whether they be day care centers, Head Start programs, or traditional nursery schools, are the ideal settings to forge ahead with integrating "special" children and provide habilitative programming before problems are compounded by failure experiences.

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MINIMUM BRAIN DYSFUNCTION

It was not until second grade that Jon's teacher realized that he was performing on a failing level. He had always tested above average in intelligence but had difficulty with his academic skills. Jon would seek class attention, display inappropriate behavior or become lost in his own thoughts whenever faced with classwork. In addition, he constantly squirmed in his seat and was easily distracted by the slightest sound or movement.

Jon is one of many children who display characteristics of learning disabilities --known under many labels such as minimal brain dysfunction, dyslexia, neurologically impaired or perceptually handicapped. These children are not retarded but have difficulty processing sensory information entering into their brain.

Minimal brain dysfunction can be attributed to a wide number of possible causes. It may be transmitted genetically--four or five times as many boys as girls have this problem. One study found a 30 to 40 percent correlation between the parents' problems and those of their offspring (Silver, 1971). Fetal maldevelopment and oxygen deprivation at birth are also suspected causes. Besides these genetic and organic causes, emotional problems may be a contributing factor if the child is deprived of normal steps in his childhood development (Gilmore, 1975). Of course, emotional problems can precipitate from the child's already frustrating inadequacies of learning.

The problems of MBD children can occur at all levels of learning. Jane E. Brody classifies them in four basic areas of difficulty:

1) How children receive information from their senses. A child may see "cat" but it is processed in his brain as "tac," or he may see "b" but it is processed as "d." He may be asked how old he is and answer "fine" thinking he was asked "how are you."

2) How information is integrated. The letters b-a-t cannot be put together to read the word "bat" although the child knows the sounds of the letters.

3) How information can be retained, such as visual memory or auditory memory. A child may hear a story read to him but will not remember it to answer questions.

4) How a child can express himself using writing or speech. A child may know the answer to a question but lacks the words to express it.

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The stated characteristics deal with a central perceptual problem in interpreting visual and auditory stimuli. Another characteristic of MBD children is perseveration. A child may be discussing a particular point and is unable to stop when presented with a new topic.

Usually the disabilities are first seen as a combination of certain behavioral problems. The child may be hyperactive and highly distractable. He is attracted by everything simultaneously in his environment--unable to filter out the important stimuli. In some children, it is not simply the amount of activity that is extreme, it is that the activity is inappropriate. The child seems unable to inhibit, when inhibition is appropriate (Wender, 1971). Due to this the child cannot concentrate on any one task successfully for a considerable amount of time, resulting in a short attention span. The hyperactive child often shows difficulties in coordination. Fine motor control used with cutting, coloring, tying, buttoning and writing is limited. Gross motor control such as running, balancing, hopping and skipping may also show difficulties. His coordination may be bad, such that his hand will not do what his brain tells him. Poor eye-hand coordination makes it awkward to throw and catch a ball (Wender, 1971).

It is more difficult to recognize a child with a less overt learning problem. The child may feel frustrated and angry when he knows he is trying as hard as he can without teachers or parents believing that he is. He then begins to develop a low self-image and less self-confidence. To often prove himself the child will either become destructive or withdrawn--always acting in a defensive way. Crawford (1966) sees this reflected by the child's drawing of his body image, which shows severe distortions of the human figure.

Because the nature of their difficulties vary, treatment must be programmed to the individual needs of the child with MBD. Techniques will either focus on the child's strengths and not punish him for his weaknesses, deal directly with his weak points, or both (Brody). It can be applied in special schools, special education classes, resource rooms, the regular classroom, or at home by the parents. Often when distracting stimuli are reduced in a setting where there is less interference with a learning activity. Parents and teachers must encourage the child and support him through this difficult period.

When MBD makes it impossible for a child to focus on a task, drug therapy is frequently used. It is important to note that although drugs, such as stimulants alleviate the child's motor and attentional disorders that interfere with learning, they do not produce learning. One of the major complaints about the use of drugs is the fact that doctors are too quick to use them. This is a current and very controversial issue.

THEME REPORT

Phillipa H. Campbell

MOTOR DIFFICULTIES IN THE LEARNING DISABLED CHILD

One of the predominant characteristics of the so-called learning disordered or perceptually handicapped child is frequently his inability to perform gross and fine motor skills with the skill and coordination appropriate for his age level. The child's "clumsiness" has been identified as a diagnostic sign by Kephart, Ayres, Myklebust, Barsch, Cruickshank, Cratty, and Delacato, as well as others who have been instrumental in developing the theoretical basis for diagnosis and treatment of the child with learning difficulties.

Recent research conducted by Ayres (1973) analyzed test score patterns of children already placed in educationally-handicapped classes in southern California. Using factor analytic methods, Ayres identified six predominant factors which she labeled according to the predominant psychoeducational and mild (soft) neurological signs demonstrated by children whose test scores loaded on these factors. The statistical analysis has enabled her to hypothesize that children show varying types of difficulties in integrating sensory information which they receive. This approach, although more neurologically oriented, is not that different from the information processing model which has been suggested by Hunt (1961) and which has formed the rationale behind many of the psychoeducational approaches to assessment and treatment of this type of child. Basic to all learning are the methods by which the child receives, interprets, stores and retrieves and responds to information which he receives from his interaction with his environment.

An individual has only two modes through which he is able to respond to incoming stimuli. Communication--talking, gesturing, writing--provides the child with a verbal method of response. Non-verbally, he is able to respond through the motor channel using varying degrees of motoric sophistication--pointing, manipulating, paper and pencil skills such as tracing, copying, drawing, etc. He receives information from the visual, auditory, tactile, kinesthetic, and vestibular senses and to a lesser degree from tasting and smelling. The extent then to which the child is able to take in information from a sensory modality, process this information, and integrate it with either a "verbal" or motor response is what is assessed when the child's learning skills are evaluated.

Developmentally, it is accepted that the very young child interprets incoming sensory information with a somewhat different emphasis than either the preschool or school-aged child. Because of the maturational process of development as a whole, the child is able to interact with or respond to his environment with varying levels of skills, coordination, and sophistication at varying ages. The infant or the three-year-old would not be expected to demonstrate the same skilled motor responses that would be expected from the six-year-old. The learning skills of the child--his ability to interpret and

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respond to incoming stimuli--are assessed with respect to his developmental maturation not only in terms of what type of response we expect, but also with consideration to the sophistication of that response.

Whereas many of the psychoeducational theorists deal with the learning disabled child's problems in terms of the results of the response or the product which comes about from the child's ability to receive sensory information and respond to it, Ayres has suggested that the difficulties not only lie in the processing of the information, but that the child's ability to process (or integrate) the information can be facilitated exclusive of the particular stimuli which are being received or the response which is being required. It is her emphasis on the processing of information which separates her theories from those of other contributors to the field.

The child with difficulty integrating sensory information may then, in fact, have incomplete abilities in processing information. To this extent, it is the quality of the response which is significant, not just the presence or absence of certain skills. Ayres has suggested that processing or sensory integrative difficulties can be grouped into six syndromes--Bilateral Motor Integration; Tactile Defensiveness; Form and Space Perception; Apraxia; Disorder of the Left Side of the Body; and Language Problems. Because the intervention or treatment then is based not only on facilitating processing but on also the neurodevelopmental aspects of processing, the treatment strategies are based on neurological facilitation techniques rather than predominantly on the psychological or educational aspects of the information processing learning model. The emphasis is on facilitating the child's ability to process or integrate sensory information so that his "readiness" or ability to interact with his environment will be enhanced before providing him with the educational "practice" activities which will give him experience in interpreting, integrating, and responding appropriately to his environmental learning opportunities.

THEME REPORT

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CROSSING THE MIDLINE

Sensory and motor functions of the body are controlled by the brain. The brain is divided into two halves or hemispheres which provide control to opposite halves of the body. The right hemisphere processes sensory and motor information for the left side of the body. The left side of the brain, the left hemisphere, processes for the right side of the body. As such, actions performed exclusively on one side of the body are controlled by the opposite side of the brain. The two sides of the brain, however, are connected so that communication and integration exists between the two brain halves. This communication function provides the processing and control necessary to perform activities and skills which are not performed exclusively by one side of the body but which require integration between those sides of the body. Crossing the midline refers to the ability to cross (generally with the arms or legs) an imaginary line which vertically divides the body into two halves, a right and a left side.

Crossing the midline is a skill which is not present at birth and which the child usually acquires through the developmental process. It is hypothesized that the ability to cross the midline of the body develops after the child has developed bilateral body integration. In viewing the development of upper extremity skills of reach and grasp, it is apparent that the young infant's reach is initially unilateral before it becomes bilateral from a supine position. The ability to bring both hands to midline then develops prior to the child being able to use one hand unilaterally across the midline. Upper extremity skills appear to develop in the normal child in this progression regardless of the position in which reaching is being observed; however, as the child learns to use his arms from positions, such as sitting, which are maintained against gravity, the development of emancipation of the arms with equilibrium reactions is a necessary precedent. It is not until the infant has developed sufficient balance in sitting that he is able to free his arms for use for reach bilaterally. Crossing the midline of the body in any position requires the development of sufficient balance to maintain the arms while using the arms. There are no fixed normative data concerning the age at which the ability to cross the midline is present consistently. Inspection of the developmental process in normal children would suggest that the skill is present consistently by 3 to 4 years of age; however, the manner in which crossing the midline skills are assessed has considerable influence on determination of whether the skill is present or not. It is hypothesized that this skill is representative of the degree of integration that is present between the two brain hemispheres, however, at this point, conclusive information regarding this relationship is not available.

Observation of children with developmental and/or learning disabilities has shown that many of these children don't cross or inconsistently cross the midline of their bodies. Sometimes, lack of crossing may be less spontaneous or

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less consistent with only one arm. Frequently, these are the children who appear not to have developed handedness. (Parents, when questioned about their child's handedness, frequently respond that he is ambidextrous.) Fine motor skills (exclusive of visual-motor skills), frequently appear fairly equal for both hands and usually skill is below age level. Difficulties with left to right progression (especially if the child is right handed), with sequencing both visual and auditory stimuli (verbal and non-verbal), and with visual and auditory reversals frequently accompany the problem.

Jean Ayres, as well as other perceptual-motor theorists, views crossing the midline as a manifestation of difficulties with postural and bilateral motor integration. She suggests that earlier reflexes, which in normal development become integrated and "inhibited" by the central nervous system, are not fully integrated and subsequently, influence the child's development and skill in subtle ways. From this viewpoint, the problem then is one of a group of difficulties which might suggest lack of integration within the brain and central nervous system. Remediation, then, is geared toward providing activities which, through their structure and organization, should encourage more complete integration of the postural reflexes, development of equilibrium reactions, and spontaneous use of crossing the midline. For specific activities refer to the report in this publication "Activities Which Help Remediate Sensory Integrative Dysfunction."

It is, however, important not to force the child to cross the midline or to direct his attention to whether or not he is crossing. Crossing the midline is a manifestation of a larger problem, however, the child can acquire skill in this area as a "learned" behavior. In this manner, the child learns to cross the midline for specific activities but does not develop the neurological integration or the consistency to make the skill truly functional.

The secondary problem of lack of fine motor skill requires remediation in addition to providing the child with opportunities to develop integration. Normal children, as they develop "dominance" or laterality, practice fine motor skills to a greater degree with one hand than with the other. Children who have not developed the ability to cross the midline of their bodies, frequently use both hands and subsequently never practice fine skills with one hand more than the other. The child who doesn't, or who inconsistently crosses the midline, usually has a major hand. It is necessary to provide the child with activities which will help to develop fine motor skills in his major hand.

In addition, it is frequently necessary, especially if the child is of school age, to also provide activities to develop a left to right progression both with the eyes and with the hands, to facilitate sequencing for both verbal and non-verbal material, and to remediate reversal problems both in visual recognition and in writing, if these problems are also present.

Many activities can be used to develop both bilateral integration and crossing the mid[illegible]ne. Perceptual-motor curriculums and activity guides, educational manuals, and imagination provide the best sources. Additional information concerning this area of difficulty is available in: Ayres, Jean. Sensory Integration and Learning Disorders. Los Angeles, California: Western Psychological Services, 1972.

Arlene R. Cohen

ACTIVITIES WHICH HELP REMEDIATE SENSORY INTEGRATIVE DYSFUNCTION

The following activities are specific suggestions used to remediate sensorimotor deficits. As is noted, many of the activities are those used daily in quality day care programs. To further understand the philosophy supporting these suggestions, refer to the reports in this publication, "Motor Difficulties in the Learning Disabled Child" or "Crossing the Midline."

I. Bilateral Motor Integration. This is the coordinated use of two sides of the body.

1. Symmetrical Bilateral Activities. The ability to use two sides of the body together.
   a) throwing or hitting a ball with two hands
   b) hopping or jumping with both feet together
   c) swimming
   d) games which involve clapping
   e) chalkboard activities: holding a piece of chalk in each hand, the child is required to make large circles simultaneously
   f) angels in the snow

2. Reciprocal Bilateral Activities. The ability to use two sides of the body alternately.
   a) climbing a ladder
   b) riding a bicycle
   c) swimming
   d) wheelbarrow: the child "walks" on his hands with feet held, following a specific route
   e) balance beam

3. Vestibular Stimulation (movement). This is another method of integrating bilateral skills.

   Methods:
   a) some children are fearful of movement experiences or become dizzy easily. Therefore, activities should be introduced slowly and never forced upon a child
   b) if a child becomes flushed or nauseated, discontinue the activity

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Activities:
a) rocking in a chair, jump rope, roller skating, riding a bicycle
b) playground activities: swings, slides, merry-go-rounds
c) jumping, hopping, running

4. Crossing the Midline. The ability to cross an imaginary line through the center of the body which divides it into right and left sides.

Methods:
a) try to direct the child's attention to the activity and not crossing the midline
b) never force a child to cross his midline

Activities:
a) Simon Says: Simon requests positions which involve crossing the midline
b) throwing ball, darts, etc., standing sideways to the target
c) stamping: place a strip of paper horizontally in front of the child from his far left to right, and have him make a design using a rubber stamp or potato prints

II.

1. Tactile Discrimination. The ability of the brain to interpret what we feel. Although a child has full sensation in his hands, he still can have problems in such areas as knowing where he was touched, or what kind of shape or object was placed in his hand, etc.
* a) provide activities with tactile stimulation: shaving cream, clay, play dough, finger paint, water, sand (wet and dry)
b) draw a design or letter on a carpet sample with chalk, and have the child erase the marks with his hands
c) have the child match textures by touching various materials, e.g., smooth, soft, rough (with vision occluded)
d) grab bag: place various objects in a bag, and have the child find a certain one, using his hands only
e) localization on touch: with vision occluded, touch the child in different areas to see if he can accurately locate the spot where he was touched
f) have children feel a shape, and then draw what they have felt

2. Tactile Defensiveness. This is an adverse response to certain types of tactile or touch stimuli.

Methods:
a) only provide the amount of tactile stimulation that a child can tolerate
b) allow the child to see where he is being touched, as the unexpected appears to be more threatening
c) a child should never be forced to do tactile activities he dislikes

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Activities:

a) provide activities using various types of textures (see Tactile Discrimination *a)
b) baking cookies: have children mix cookie dough with their hands
c) paper mache, pasting and gluing using fingers
d) swimming
e) rolling on carpets, mats, and various other textures

III. Visual Perception

1. Visual Tracking. The ability of the eyes to smoothly follow a moving object.
   a) games which require the child to track or fixate on a moving or stationary object
   b) ring toss, darts, bean bag toss, horseshoes, balloon volleyball, badminton, croquet, watching television, movies, and cartoons

2. Figure Ground. The abioity to separate an object in the foreground from objects in the background.

   Method:
   a) figure ground training, pencil and paper exercises should be preceded by games and exercises involving three-dimensional objects

   Activities:
   a) discriminating objects in a room: children are required to point out various categories of objects in a room, e.g., find all the round things, blue things, etc. As the children become more skilled, they are required to pick out more specific things, e.g., a ball, a calendar, etc., and then less conspicuous objects
   b) finding objects that are different: finding a small ball among large ones, finding blue blocks among red ones
   c) sorting: have children sort objects of different shapes into various piles, e.g., circle and square. Then add a third shape. The same can be done with colors--start with red and yellow, then add green
   d) take children outside for a walk, and have them point to the various things they see, e.g., green car, brown dog

3. Position in Space. The ability to perceive the relationship of an object to the observer
   a) body awareness: have children touch various parts of their body as you name them, and move the parts named
   b) function of body parts: naming different parts of the body and what they do
   c) people puzzles: have children assemble puzzles of people
   d) show children pictures of various poses, and have them imitate the positions

IV. Apraxia. The inability to plan and carry out a skilled, non-habitual motor act in the correct sequence from beginning to end. It is not a motor coordination problem, but a problem in the organization of incoming sensory stimuli.

Methods:

a) give simple verbal directions, one step at a time
b) if the child is unable to follow directions, use demonstration
c) if he is still unable to do the activity, take his body through the motion so he feels what it is like to go through the task
d) vary activities, as new activities place a different demand on the child
e) first, introduce gross motor activities, and then gradually introduce fine motor activities

Activities:

a) gross motor: Follow the Leader, Simon Says, Twister, obsta obstacle course
b) fine motor: stringing beads, sewing cards, making paper ring chains, weaving paper strips, follow-the-dot exercises, tracing

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THEME REPORT

Beverly Bailey

DANGER SIGNALS IN THE SPEECH AND LANGUAGE DEVELOPMENT OF PRESCHOOL CHILDREN

Certain speech and language behaviors displayed by preschool age children are frequent predictors of future learning problems. When these behaviors are observed and reported early by preschool teachers, children can become involved in treatment earlier, their problems are more likely to be remediated, and their chances of returning to and succeeding in regular classroom settings are better. However, too often children with learning problems are not identified until after they have failed in school. Once this has happened, not only does the child's learning problems have to be dealt with, but also her/his self concept as a failure. Preschool teachers can attend to several aspects of children's communicative behavior to determine if speech and language are developing normally.

Children must master many basic concepts in order to learn in a regular classroom setting. These are concepts which teachers use in explanations and instructions, assuming that students understand. Among the concepts commonly misunderstood by children with learning disabilities are: the directional and spatial relationships such as in front/in back, between, through, next to, first, last, middle, narrow/wide, toward/away from, and above/below; the temporal relationships such as before/after, always/never, and beginning; the quantitative concepts such as some, few, many, most, several, almost, half, zero, every, and equal; and many miscellaneous concepts such as not, different and alike. Obviously, a child who does not comprehend several of these concepts will be lost in a classroom setting. However, children with language-learning problems frequently are very quick to learn to take cues from other children in order to perform required tasks, thus obscuring their own lack of understanding. Be certain that each child understands and is not simply following the lead of others.

By listening carefully to children's grammar, a teacher may identify a problem which may be indicative of learning disability. In the preschool years, many children with learning disabilities exhibit grammatical errors which are not typical of their age or of their family or community dialect. For example, morphological inflections which denote plurals (s, es), tenses (ed, ing), possession ('s), or subject-verb agreement, are often omitted. Function words such as articles or auxiliary verbs may be omitted. Word order in sentences may be confused. The child may not use verb tenses differentially. Many errors which are typical of children at age three should be corrected by age four or five.

By age four or five, most of a child's speech should be intelligible to strangers. Articulation errors are still present, such as w/r, y/l, or th/s, but a child whose articulation is so defective that most of her/his speech is difficult to understand should be seen by a speech pathologist.

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Some children will repeat part or all of what is said to them rather than respond appropriately. This is called echolalia. Echolalia always means that the original question or direction was not understood. Some echoing is normal as children learn language; however, if a child seems to be echoing language that other children in the class understand, it is a reason for concern.

A severely limited auditory sequencing and retention span (inability to retain and repeat sentences or series of digits or words in sequence) is extremely common in children with learning disabilities. A four or five-year-old child should be able to repeat a sequence of four digits (Illinois Test of Psycholinguistic Abilities). A four-year-old should be able to repeat sentences of five to seven syllables, and a five-year-old, twelve syllables (Stanford-Binet Intelligence Scale norms).

It is important for preschool children to be able to follow instructions involving more than one step, such as "touch the big truck and the little ball" or "go to the table and pick up the pencil." Many children with learning problems have difficulty doing this either as a result of not understanding the language or not remembering the entire instruction long enough to carry it out.

The above problems can be indicators of several different disabilities. In fact, in some cases one or more of them will be present in a normal but slowly developing child. It is not the purpose of this article to present a means of diagnosing children, but simply to call the attention of preschool teachers to speech and language behaviors which are known to frequently accompany learning disabilities. A child who exhibits one or more of these behaviors should be referred to a speech pathologist for evaluation.

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THEME REPORT

Mary Frank

VALUE OF PLAY FOR CHILDREN WITH LEARNING DISORDERS

Danny is diagnosed as having severe articulation problems. One morning when he walked into school, his first words were "me pay ecor" (me play doctor). Johnny who has severe visual-perceptual deficits said: "Today, I'm going to paint at the easel. Last night I decided I wanted to paint this morning." On another morning, Jane who has a tragic family history walked into the classroom and said to Susie, "Let's you and me play house today, okay?"

These statements reflect how dynamically important play is to young children who have various learning disorders. Parenthetically, it is indicative that play is an opportunity to sense and develop a feeling of autonomy, as well as develop an ability to organize one's life and develop what would be for them long-range goals.

There is little or no research on the social development of young learning disabled children because it is a relatively new field and most of the research has been centered on diagnostic and remedial intervention. However, research done by Tanis H. Bryan, Ph.D., in 1974 at the University of Illinois, supports what children are telling the professionals. Play is important, and important for more reasons than it is for the normal child. She researched peer popularity among normal and learning disabled children in first grade. The resultant findings indicated the social status of such children, depending upon their race and sex, is significantly different from that of the non-disabled children. Learning disabled children, particularly white children or female children, are rejected by classmates for several reasons, but mainly deficits in attention, language and perception prevent the child in detecting critical cues or making inferences about people just as they appear to prevent the child in the acquisition of academic information. Dr. Bryan concludes there is a need for educational programs which have social/affective components as well as cognitive/achievement goals.

With this perspective on the social development of the learning disabled child, it is imperative that concentrated efforts are made to remediate social deficits during the young child's developmental years. For these children who have language deficits, visual perceptual deficits, auditory perceptual deficits, gross and fine motor deficits, hyperactivity, and short attention span, the broad-based conceptual framework of reference on play which has been contributed to by Erikson, Freud, Liberman, Piaget, Smilansky, et al., and is functional for young normal children, would also provide the concepts which would be instrumental in remediating some of the above-mentioned deficits, as well as some of the social, cognitive, emotional and physical deficits of these children.

What then are some of these theories on play that would be applicable to this child. Anna Freud states that play is the child's way of externalizing his/her

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inner life or it is the process through which a child can reconcile the stresses and pressures of the inner and outer world. From Erikson we learn that play is a child's way of making sense of the world of grownups and coming to terms with the rules of civilized behavior. Karl Groos believes play is practice for future adult functions. Piaget identifies play as an aspect of intelligence and calls attention to the important relationship between play and cognitive development. Dr. Eleanor Irwin's work with speech-handicapped and emotionally-disturbed children indicates that children made significant gains in the development of language following experiences in dramatic play.

How then can a teacher apply these theories into practice. Basically and initially, she needs to know where the child is functioning developmentally, i.e., is the child electing to play at a solitary level, a parallel level or a cooperative level. Then from the collected diagnoses of the child's deficits, she can begin to formulate goals which will either raise the level of play, formulate goals which will channel energies, or formulate goals which will remediate a specific deficit.

With this baseline, the teacher can develop techniques and strategies which achieve the established goals. To raise the levels of play, it may be necessary to utilize the same techniques Sarah Smilansky found to be successful in working with socially disadvantaged children. To facilitate this objective, she first provided "living" experiences for these children (visiting the grocery store), then helping the child translate these experiences into his/her own scheme, symbolic and imitative play system. This can be done by suggesting a role, "would you like to play grocery store," then "let's pretend you are the grocery store man" and the activities belonging to that role. To further establish or model the role, the teacher may wish to act as a grocery store lady or customer. Here the teacher is technically acting as an internal intervenor. This technique is a departure from the traditional philosophy of the teacher being an active observer. However, in remediating special deficits, there are judicious times when it is beneficial to the child when the teacher is an active participant. The teacher can be an external intervenor when the children are functioning at a parallel level of play and need suggestions which help them formulate and play out a role which will bridge the gap between parallel and cooperative play.

In planning for the hyperactive child who has no inner controls and who needs consistent external controls, this child will function better in a traditional form of the behavioral modification system. The hyperactivity will decrease also to some degree with the acquisition of language skills gained through play, and learning how to participate in dramatic play. This type of child also enjoys the structure provided by sitting at a table and playing quiet table games with a peer and an adult who will maintain the structure.

The children who are unable to intellectually integrate their visual and auditory world, benefit from sequential forms of play which are specifically broken down into parts. The sequential parts can be listed on a chart which the child cannot read but will know that to play "dentist" one must follow three or four steps. Memorizing the parts, and rehearsing the parts will help the child program himself in the actual play situation. The accomplishment of this fete will promote ego strength within the child as well as establish satisfying and enjoyable peer relationships.

Children with motor deficits benefit from all the activities used by normal children to develop motor skills. In addition to these activities, the remediation component can be added. For example, in block play, the child can be shown or asked to identify the top of the structure, side, bottom, or identify an object next to the structure. The workbench is instrumental in developing fine motor skills and establishing handedness.

Providing non-identifiable material (string, straws, empty boxes, pieces of material, masking tape, blocks, and some identifiable objects (stethescopes, some kitchen utensils, and various kinds of role-playing wearing apparel), the children can use these to enrich their spontaneous play. Frequently these materials can symbolically help the child re-enact a trauma, such as using the material to make a body cast for the doll, like the cast worn by the child following an automobile accident--or used creatively like the "doctor" who used the potato masher to check knee reflexes.

Concomitant in all these play experiences are the development and extension of language, cognitive and social skills. It is difficult to teach a skill in isolation. Each experience is a rich combination of the many values of play. Also when the play experiences are combined with the various forms of the expressive arts, play, social development and the acquisition of affective skills is made even more meaningful.

To maximize on the insightful theories of Freud, Erikson, et al., and the emerging contributions of the expressive art therapist, the teacher will find it extremely helpful if daily "play charts" are maintained. A chart which identifies specific goals for specific children and a daily chart which identifies the type of play the children are selecting or not selecting, can serve as a guide which indicates preferred play as well as indicate the types of play the children are consciously or unconsciously avoiding. A third chart should be a "log" containing the characteristics of play such as the rhythm, intensity, flow, play patterns and organization of play.

The incorporation of these many theories into practice and the important role the teacher plays as a planner, participant, observer or, as Dr. Margaret McFarland states, as a "concerned and emphatic adult" will be of value to the Dannys, Johnnys and Janes when they enter the mainstream levels. Hopefully, their social development and peer popularity will be commensurate with that of their fellow non-disabled friends.

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Dorothy Whitenack

THE USE OF STIMULANT DRUGS IN HYPERACTIVE CHILDREN

Hyperactive behavior disorders may be seen in children with specific learning disabilities. The hyperactivity may be physical in nature and the child described as "climbing the walls." These children move rapidly from place to place, from activity to activity. They often seem unable to sit still, to watch a television program or to eat an entire meal with the family. Comments are often made that this hyperactivity seems to be motor "driven" behavior with the child seeming unable to control his need for movement. One might also see a more mental type of hyperactivity characterized by short attention span and distractibility. Both types of hyperactivity often go together. It often seems that these children react to every sound they hear and to every object which comes into their visual field; they seem unable to shut out any sensory stimuli.

It is important in defining hyperactivity to understand that there may be a fine line between a normally active child and one described as hyperactive. All normal school-age children are hyperactive at times, perhaps most noticeably just before school vacations. A normal two-year-old shows patterns of activity, short attention span and distractibility which might be considered abnormal in a six-year-old. A normally very active child may be considered hyperactive if his parents expect calm and considerate functioning. Increased psychological or physical stress such as illness or disruption of family may result in symptoms of hyperactivity. The diagnosis of hyperactive behavior disorder, therefore, needs to be made by considering not only the child but his environment and to be made only with considerable experience with school-age children.

Once a diagnosis of hyperactive behavior disorder is made, a plan of treatment should be formulated. Most important in this plan is a structured environment, either at home or at school which may involve behavior modification techniques but requires the setting of firm and consistent limits. Special educational techniques may be very effective in helping the child to concentrate and organize himself for better academic functioning. Counseling may be appropriate for the child and the family. The use of stimulant drugs may be desirable as part of the overall program. It is my feeling that they should never be used by themselves and should only be used with very careful monitoring.

It is paradoxical that one would give stimulant medication to a child who already seems over-stimulated. It is not known why these drugs seem to have a calming effect on some children but effects are dramatic in some cases. It has been stated that only two-thirds of children who would seem appropriate for stimulant medications show a positive response, and this cannot be predicted before trying a drug. Ritalin is the drug most frequently used at the present time. Amphetamine or Dexadrine is also used. A school-age child is usually started on five to ten milligrams of Ritalin in the morning and again at noon. If there

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are to be beneficial results from this medication, they should be obvious to the teacher and the parents within a week's period of time. When the drugs are particularly effective, missing even one dose is noted by those in close contact with the child. One of the side effects of these drugs is a decrease in appetite which is often temporary. Sleep may also be disturbed and this is the reason for not giving the medication late in the day. It has been shown also that higher doses of amphetamines in particular seem to inhibit the child's growth in height and gain in weight. For this reason, it may be important to discontinue the drugs over a summer vacation and to monitor very closely the need for such medication. At times, these medications may increase a child's irritability and distractibility in which case they should immediately be discontinued and the bad effects would be expected to disappear.

When a beneficial result is obtained from the use of stimulant drugs, the child is not sedated, dopey or drugged. He seems to be less distractible; his attention span may be longer and he becomes better organized and more available to special teaching and behavior modification techniques. I think it is important to explain to the child why he has been given the medicine and I often relate it to his difficulty concentrating. I don't believe that medication should be continued without a definite beneficial effect. If after several weeks, the teacher or parent is not sure whether or not there has been a beneficial effect, I feel that medication should be discontinued. If the child has been on Ritalin with little effect, Dexadrine may be tried and be more effective. Even when the desired effect is achieved, the medication should be closely monitored and after several months attempts should be made to take the child off the medication. Again, if there is no dramatic deterioration in functioning, the child probably does not need the medication.

Medication should be viewed as a temporary means of helping the child achieve more control. As this control becomes internalized and stabilized and as the child grows and matures, there may no longer be need for medication. The medication may be useful in breaking up a downward spiral of failure and frustration. When monitoring the effects of medication, the placebo effects should not be forgotten. Often if people in contact with the child expect him to perform better on medication, he will meet their expectations. Improvement in behavior and functioning may have nothing to do with the medication. This may be a valid use of the medication, however, if it results in a more positive situation for a child.

There has been a great deal of controversy in the newspapers about the use of stimulants in hyperactive children. Parents are concerned over whether or not the use of these medications may result in addiction to the drug and abuse of these drugs in the teenage years. Rather the opposite has been found to be true. These children take small doses of stimulants. They do not get "high" and do not have "trips." They are able to function better and feel better about themselves.[9] It would seem that their risk of serious drug problems at an older age are minimized by constructive dealing with the behavior problems at a young school age. Another issue is the rights of parents to refuse the use of these drugs in their children and I feel very strongly that parents have this right and would only use a drug after thorough discussion with the parents of the pros and cons. The physician must be in close touch with the family to be aware of any bad effects when medication is begun. He should also be checking height and weight and considering how long the medication is necessary. If a parent feels very negatively about

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the use of medication, the negative feelings will be passed along to the child and the use of medication may do more harm than good.

The use of stimulant drugs in school-age children then should be considered only after complete and careful evaluation. It should be considered only in the context of a well-rounded treatment program for the hyperactive behavior disorder as well as any learning problems which may be present. Treatment with medication should be carried out only as long as is absolutely necessary and should always be carefully monitored. In certain situations, the addition of stimulant medications for a child already involved in a structured program may yield dramatic results.

THEME REPORT

Marlene W. Buchanan

A CLASSROOM SETTING FOR YOUNG CHILDREN WITH LEARNING DISORDERS

Children are like plants. Given an environment which provides appropriate nutrition and desirable growing conditions, most seedlings develop into healthy plants. Provided appropriate lighting and timely fertilizer, plants mature; each becomes a beautiful specimen of the species. Adults provide an environment in which children can grow naturally. Given positive interactions with a stimulating and predictable environment, most children will develop normally. Teachers are often the first to recognize children whose development is not normal. Subtle differences in the behavior of a particular preschool child can indicate that he has not established positive interactions with his environment; he is in trouble; he will not unfold and learn according to the normal developmental sequence without help.

Such a Johnny cannot depend upon himself, so he must depend upon teacher. He must depend upon a consistent and predictable structure. He needs to know that every day he removes his coat, hangs it in his locker, and then proceeds to the table for a sit-down activity. Johnny is unable to handle not knowing what is expected of him; he hasn't figured out the feedback system necessary for freedom. Johnny must likewise depend upon limits being set and enforced by teacher. If he throws sand, he depends upon teacher to consequent his behavior. External controls applied consistently will help him monitor his own behavior. Johnny needs to be provided with dependable limits and yet with real choices so that he can develop some freedom within a controlled environment: "Would you like to use the clay today or to paint at the easel?" Having made a choice, he needs help with both managing and sustaining the activity, teacher functions as a facilitator for success. Success serves every child as his most effective reinforcer; the use of other teacher selected reinforcers is often essential for Johnny's strivings when success is not close. What does he like? Cookies, stickers, affection, teacher praise. The teacher can use what Johnny likes as a reward for his efforts. Even with predictable routines, established limits, and effective reinforcement, Johnny's behavior will sometimes be inappropriate. Then, he needs removed from the group temporarily: "You may sit at the other table until you are ready." Johnny must depend upon teacher to manage his behavior.

Managing Johnny's behavior is the first step for his teacher. Secondly, the teacher can design and implement a program for Johnny's positive interaction with his environment. How has he been getting attention? Select the positives! If he does well in the gross motor area, begin designing positive interactions to occur naturally. Avoid areas where he is weak initially. Johnny perhaps first needs to establish a trust relationship with his teacher. She and Johnny can interact in a situation which pleases him--success. Johnny's positive interactions with her can be extended as he is ready to accept a trust relationship.

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Gradually one or two other children can be included in Johnny's special friend circle. For a long time his teacher will need to maintain either eye contact or verbal contact with Johnny to reassure him that he can depend upon her to both control his behavior and to structure positive interactions for him. A predictable relationship with his teacher stabilizes Johnny's own unpredictable behavior. He begins to understand the relationship between performance and consequences. Teacher is consistent!

Now the teacher has a new responsibility. Having been successful in managing Johnny's behavior and in having subsequently initiated a consistent and predictable interaction with him, she now has the task of assessing his development and designing a prescriptive program for remediating his deficits. Recognition of developmental deficits carries with it the responsibility for remediation (Keogh and Becker, 1973). Using a checklist developed on the basis of normal child development, teacher can determine Johnny's level of functioning in the various area of development: gross motor, fine motor, concept, language, social/emotional, and self-help. Specific remediation begins at the point where Johnny is functioning in each area. In language perhaps he functions at the two-year level; he is ready to learn two/three word combinations to express ideas. In the gross motor area he perhaps functions at the four-and-a-half-year level, develop reciprocating in going down steps. In Johnny's weakest area, perhaps social, task analysis can be particularly helpful as a teacher tool. Johnny doesn't take turns. What are the social prerequisite skills necessary for taking turns?

> When students do not demonstrate prerequisites for the task to be learned, these should be taught prior to presenting the more advanced task. (Stephens, 1970)

Again, the teacher must program success. Johnny's first step in remediation may be simple attending behavior. If through behavior management and teacher interaction, he still cannot attend to a learning situation, remove the stimulation. (He may need to begin attending to task in a quiet corner or booth alone with the teacher.) Begin with three to five minutes. Limit demands other than attending. Be certain the task is appropriate to his level of functioning. Reinforce him for approximations of attending at first. Once attending behavior is established, success becomes reinforcing to Johnny when he is working at his level of development in a particular area. Teacher now gradually extends his development; the next item on the checklist becomes Johnny's goal. When a difficult task is presented, cueing is often helpful. (A teacher aide can serve as a model. The teacher can say to the aide: "Miss Jane, is this a circle?") "The teacher acting as a model can provide cues to the child concerning what is expected of him." (Meacham and Wiessen, 1969.)

When an appropriate behavior management system is established, the teacher designed program for positive interactions are implemented, and Johnny is responding, the teacher once again needs to set new goals for Johnny. He must learn now to sustain attention for long periods of time; he must learn to persist when a task is difficult; he must develop independent work/play habits. Johnny must now be taught to reduce his dependency on his teacher! The teacher who gathered him in and stood him on his feet must now gently nudge him away if he no longer needs special help in growing, but perhaps he will be like some other Johnnies who will always need careful and particular nurturing.

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